

# Canadian Hospital

Journal of The Canadian Hospital Association

December, 1960

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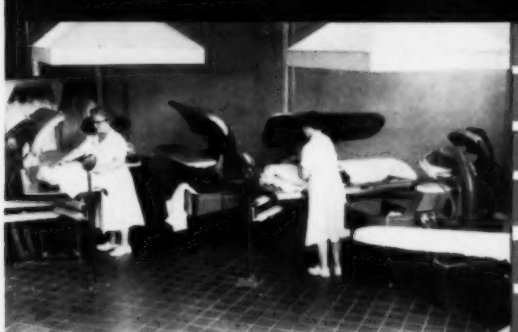

These two apparel Units, each with three easy-to-operate, high-production Presses, assure fine-quality, low-cost finishing of all hospital garments and uniforms.

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**admission and personnel check-up x-ray**

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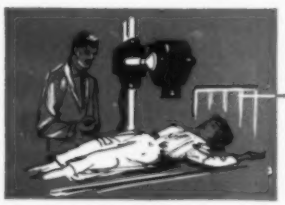
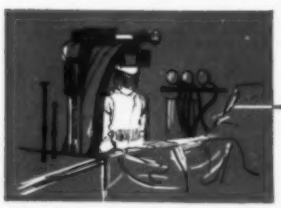


**emergency and bedside x-ray**

*Mobile x-ray units from 15 MA to 300 MA, all sharing proverbial Picker stamina to stand off the hard knocks of mobile service.*



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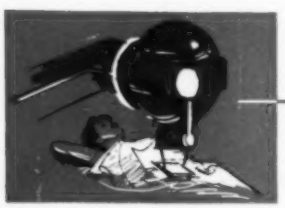

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# Canadian Hospital

THE JOURNAL OF THE CANADIAN HOSPITAL ASSOCIATION



*Editorial and Secretarial Offices:*
*25 Imperial St., Toronto 7, Ont.*
*Tel.: HU. 1-2244*

## Contents

December 1960, Volume 37, No. 12



*Cover Picture—The Hospital For Sick Children, Toronto, Ont.*

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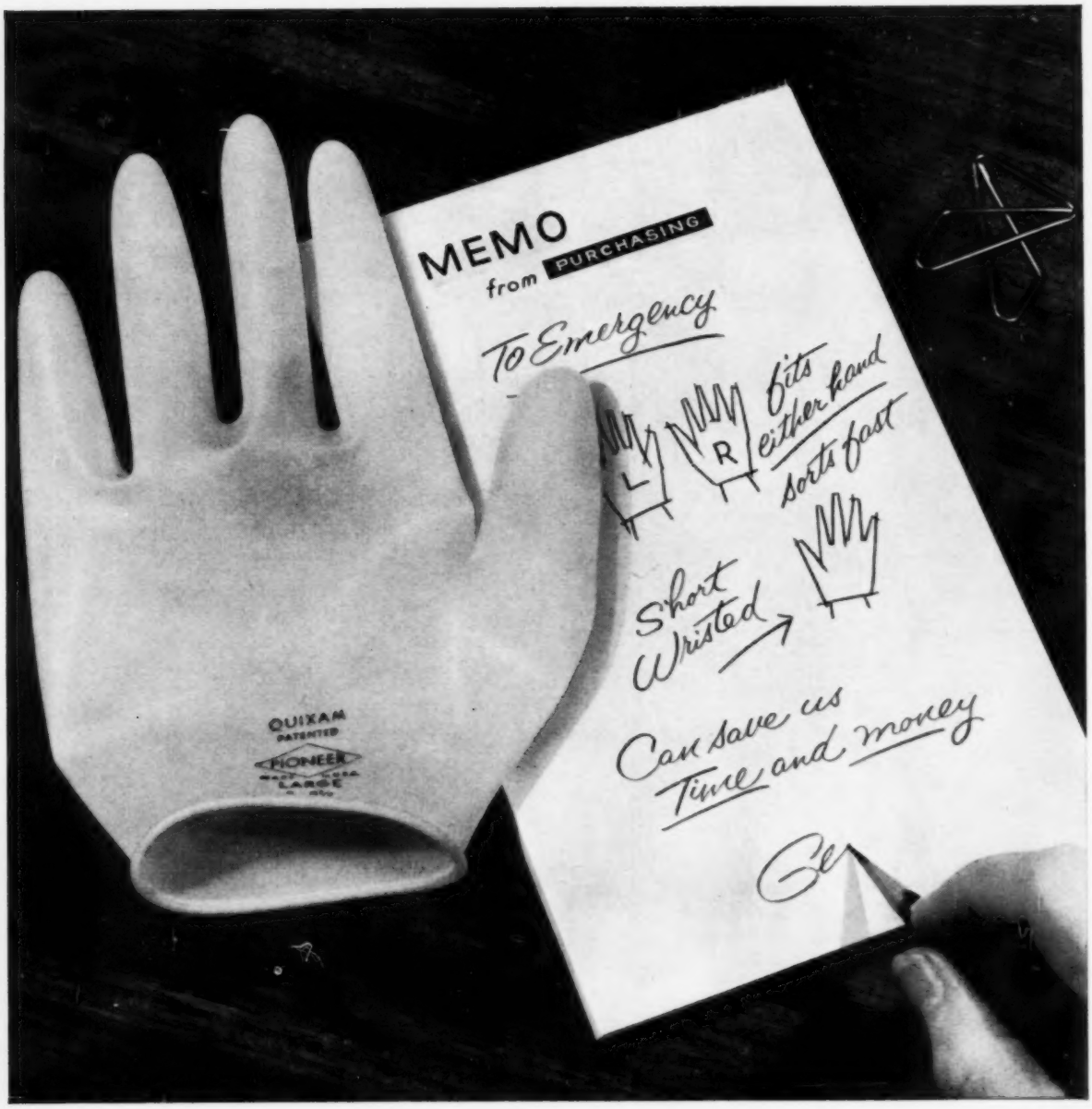


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*FREDETTE, V.: The bacteriological efficiency of air-conditioning systems in operating-rooms, *Can. J. Surg.*, 1:226, 1958.

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# Notes About People

**Dr. Harold Griffith Honoured**

Dr. Harold Griffith has been awarded the American Society of Anaesthesiologists' Distinguished Service Award, for his many contributions to the practice of anaesthesia. Dr. Griffith, emeritus professor of anaesthesiology at McGill University, is known as one of the originators of curare therapy in clinical anaesthesiology. At the present time, Dr. Griffith is medical superintendent of Queen Elizabeth Hospital in Montreal and he is one of the original members of the American Society of Anaesthesiologists.

**Alice Girard Honoured**

Alice Girard, R.N., B.Sc., M.A., immediate past president of the Canadian Nurses Association, director of nursing and assistant to the director general of Hôpital Saint-Luc, Montreal, Que., was invested Officer Sister of the Most Venerable Order of the Hospital of St. John of Jerusalem. The investiture was held by the Prior of the Priory of Canada, His Excellency Major-General Georges P. Vanier, Governor-General of Canada, at Government House, Ottawa.

**Robert Wood Johnson Award**

The University of Toronto recipient of the Robert Wood Johnson Award for 1960 is John E. Osborne, consultant on hospital administration in the department of National Health and Welfare, Ottawa. This award of $1,000, made available annually by the Johnson and Johnson Company, is given to the member of the class in a Canadian university course in hospital administration who shows the most promise of making a real contribution to the field.

Mr. Osborne is a graduate in economics of McMaster University (B.A. '43) and of the University of Toronto (M.A. '46). Positions held prior to his enrolment in the graduate course in hospital administration have included: lecturer in economics at Waterloo College and McMaster University, and research economist, Health Insurance, Department of National Health and Welfare.

**Dr. John Mann**

Dr. John Mann, obstetrician and gynaecologist at the Toronto General Hospital since 1931, died early last month. Dr. Mann, who was also on the teaching staff of the University of Toronto for 30 years, was widely known for his development of a resuscitator for babies. He also developed rotating forceps used in difficult deliveries. During his lifetime, Dr. Mann had won several distinguished awards for his contributions to this particular field of medicine.

**At Toronto Psychiatric Hospital**

John George Dewan, M.D., has been named the new director of the Toronto Psychiatric Hospital. He succeeds Dr. Aldwyn B. Stokes who will assume full-time responsibility as professor and head of the department of psychiatry at the University of Toronto. Dr. Dewan acquired his extensive qualifications in the medical and psychiatric fields as well as in biochemistry at several universities — in Ontario, England and the United States. Dr. Dewan is a member of council of the Royal College of Physicians and Surgeons of Canada and president-elect of Canadian Psychiatric Association as well as being a member of a number of professional societies.

**New Chief for Nutrition Division**

The new chief of Nutrition Division in the Department of National Health and Welfare is J. Edgar Monagle, M.D. Dr. Monagle replaces Dr. L. B. Pett who became principal medical officer in charge of research development.

Dr. Monagle has had extensive experience in the nutritional field. During the second world war he participated in the nutritional surveys conducted by the RCAF and he has also taken post-graduate training in public health nutrition at the University of Minnesota. Dr. Monagle has participated in research projects of the United States Army and has been Canadian representative at a number of international scientific meetings on military nutrition.

**New Superior at L'hôpital Ste-Justine**

The Rev. Sister Noémi de Montfort, at the L'hôpital Ste-Justine in Montreal, has recently been named superior. Sister Noémi was assistant administrator at that hospital for many years and took a very active part in designing the new hospital.

**Appointments, U. of T. 1960 Class in Hospital Administration**

Following are the appointments of the 1960 class in hospital administration of the University of Toronto: H. J. Bright, M.D., (Group Captain) C/O, R.C.A.F., Station Hospital, Rockcliffe, Ont.; C. E. Dosdall, hospital consultant, Division of Hospital Administration and Standards, Department of Public Health, Regina, Sask.; D. P. Fish, administrative assistant, Ottawa Civic Hospital, Ottawa; D. Gee, M.D., assistant director (medical), University Hospital, Saskatoon, Sask.; J. R. Haslehurst, Education Department, Canadian Hospital Association, Toronto, Ont.; F. G. MacHattie, surgeon captain, R.C.N., Canadian Forces Hospital, H M.C.S. Stadacona, Halifax, N.S.; H. D. MacDonald, M.D., director,

*(continued on page 22)*

*At the presentation, l. to r., John Macdonald, Johnson & Johnson; Eugenie M. Stuart, associate professor, Department of Hospital Administration, University of Toronto; John E. Osborne, Department of National Health and Welfare, the recipient of the award; Dr. Andrew Rhodes, University of Toronto; and Dr. Harvey Agnew, professor of hospital administration, University of Toronto.*

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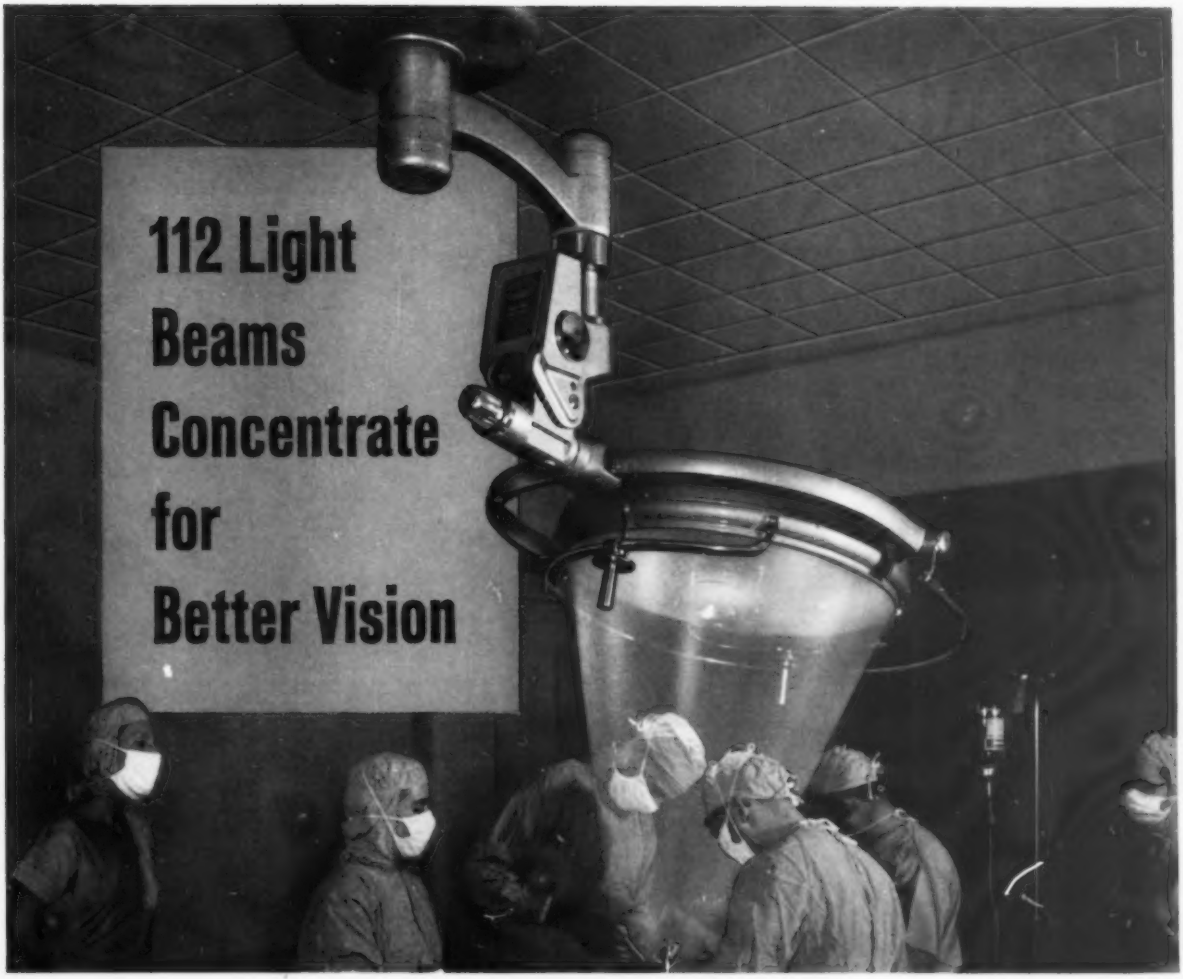
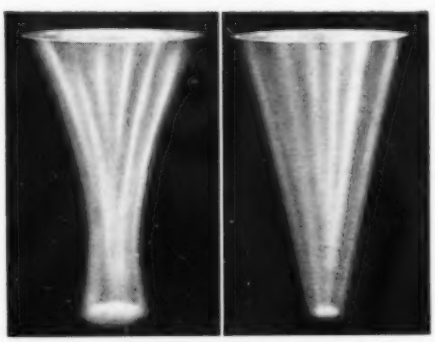



## Castle "60 SERIES" FLOODS THE WOUND WITH NEAR SHADOWLESS LIGHT



*Beams from single reflector (right) tend to be more parallel, easily blocked; focal range is relatively narrow, requiring constant adjustment. By contrast, Castle Multi-Beam Light (left) is always in proper focus; gives unsurpassed shadow reduction.*

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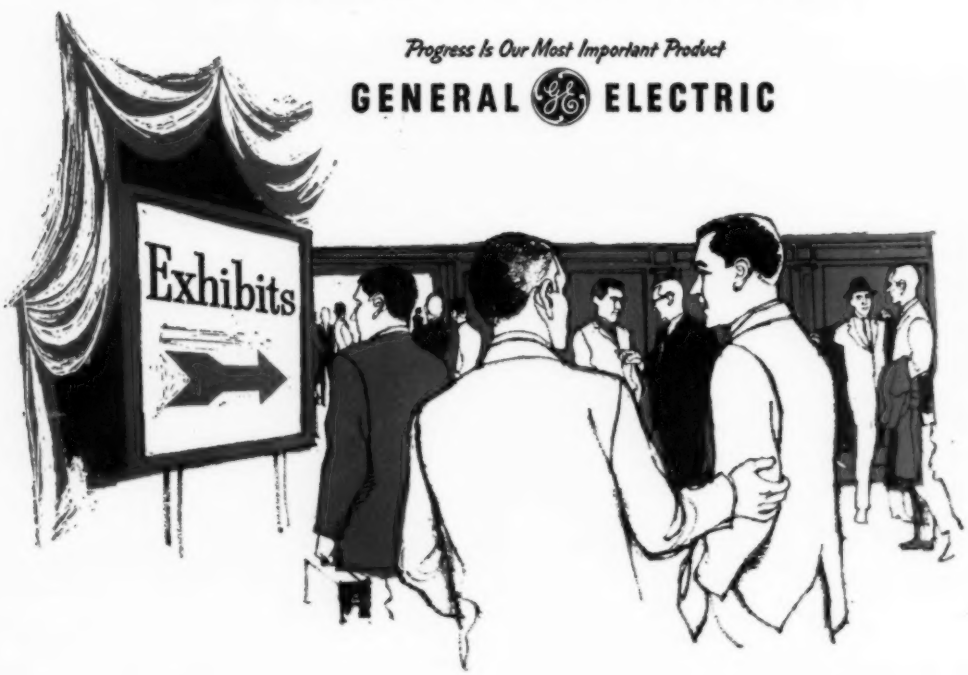


## People

*(continued from page 12)*

Division of Hospital Administration and Standards, Department of Public Health, Regina, Sask.; J. D. Medhurst, M.D., surgeon Lt. Cdr., C/O surgeon general, National Defence Headquarters, Ottawa; J. E. Osborne, consultant in hospital administration, hospital insurance, National Health and Welfare, Ottawa; J. J. Segalla, assistant administrator, Paul Kimball Hospital, Lakewood, N.J.; E. N. Stefanuk, administrator, Weyburn Union Hospital, Weyburn, Sask.; A. R. Thorfinnson, hospital consultant, Division of Hospital Administration and Standards, Department of Public Health, Regina, Sask; and Werner Mattersdorff, doing further postgraduate work in medical care and medical care statistics through a fellowship at the University of Pittsburg.

### Dr. Hardman Appointed

Lt. Col. A. C. Hardman, C.D., M.D., has been appointed chief of Emergency Health Services Division in the Department of National Health and Welfare.

Dr. Hardman served in the second world war as infantry officer and also in the Korean War. After attending the Canadian Army Staff College in 1954, Dr. Hardman was appointed chief instructor of the Medical Joint Training Centre. In 1958 he became director of studies at the Canadian Forces Medical School, Camp Borden, Ontario.

### Appointment at Canadian Civil Defence College

The new commandant of the Canadian Civil Defence College at Arnprior, Ontario, is Lt.-Col. Charles Leslie Smith.

Col. Smith has served at the National Defence Headquarters, Department of Veterans Affairs, and as chief instructor at the Canadian Civil Defence Technical Training School. Upon the establishment of the Federal Civil Defence Headquarters, Col. Smith was appointed director of the training and education section.

### Officers of the C.H.C. of Saskatchewan

The following are officers of the Catholic Hospital Conference of Saskatchewan for 1961-1962: *president,* Sister Helen Joseph, C.S.M., St. Peter's Hospital, Melville; *vice-president,* Sister Beatrice Bigelow, St. Therese Hospital, Tisdale; *past president,* Sister M. Priscilla, C.S.J., St. Joseph's Hospital, Estevan; *chaplain,* Rev. C. S. Godin, Providence Hospital, Moose Jaw; and *secretary-treasurer,* Sister Olivia Frances, C.S.M., St. Peter's Hospital, Melville.

### New Assistant Pathologist Appointed

Karl Pintar, M.D., of Austria replaces W. A. Harland, M.D., as assistant pathologist at the Jewish General Hospital in Montreal. Dr. Harland resigned to accept a teaching position at the University of the Federation of West Indies.

Dr. Pintar received his M.D. degree in Austria and completed his training requirements in pathology at several hospitals in Montreal and at McGill University.

### B.C.H.I.S. Staff Appointment

G. D. Sotiroff, Ph. D., has joined the staff of the British Columbia Hospital Insurance Service as director of research. Dr. Sotiroff was, prior to this appointment, with the government of Saskatchewan, first with the Department of Public Health and then with the Department of Labour as director of research and planning.

### Administrative Assistant Named at J.G.H.

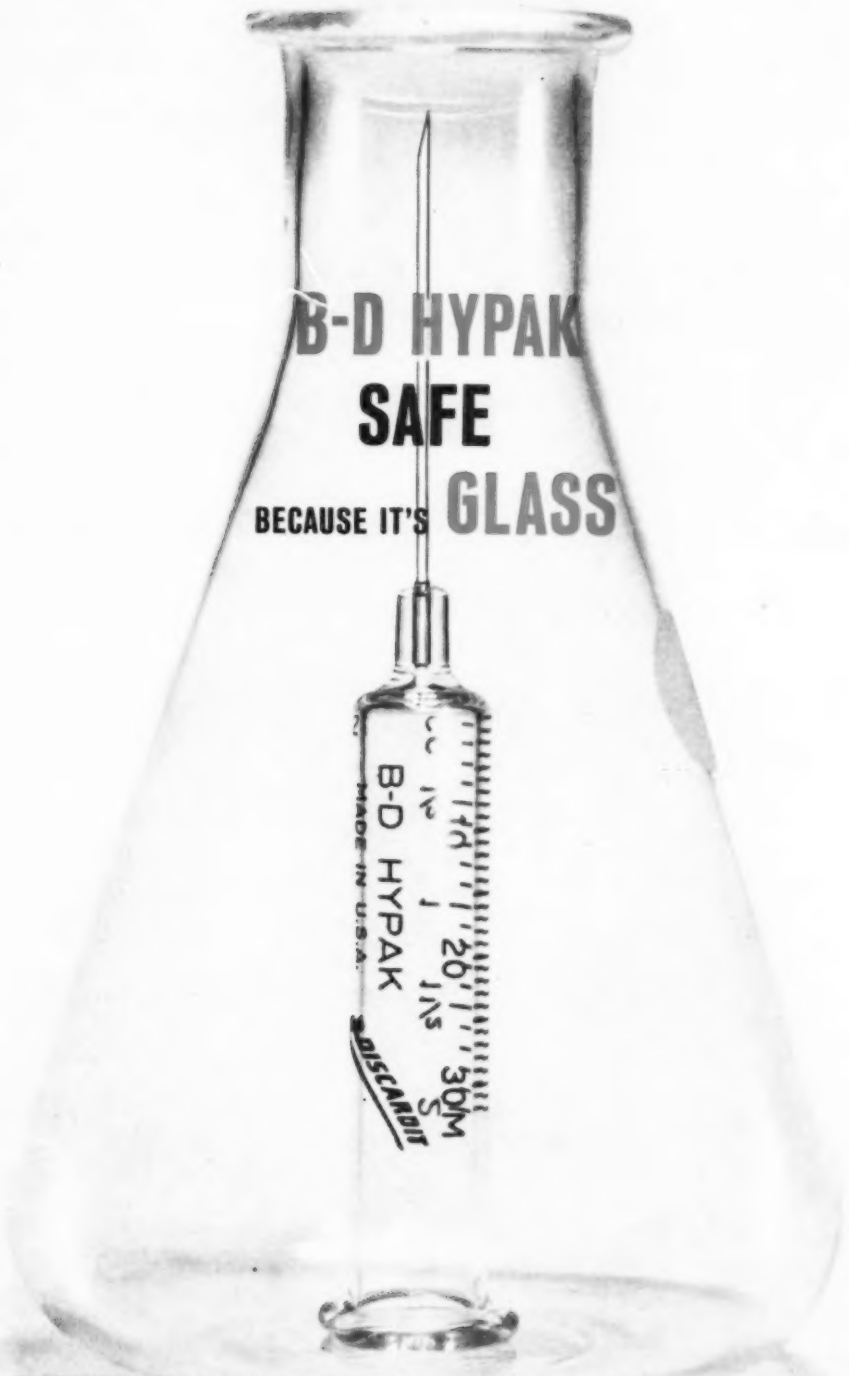
Archie S. Deskin, former executive director of the Montreal Hebrew Old People's Home, has been named administrative assistant of the Jewish General Hospital, Montreal, Que. Prior to his appointment, Mr. Deskin graduated from the University of Montreal School of Hospital Administration.

- D. M. Rice, M.D., has been appointed recently to the St. John's Sanatorium in St. John's, Nfld., as assistant superintendent. Prior to this appointment, Dr. Rice was working at the Tuberculosis Dispensary.

- C. H. Potter, M.D., will be leaving his position as superintendent of the Hospital for Mental and Nervous Disease, St. John's, Nfld., to take the newly created post of director of Mental Health Services for that province. His place will be taken by J. F. Walsh, M.D.

- Former assistant administrator and bursar at the Hotel Dieu Hospital in St. Catharines, Ont., Sister V. Callaghan has accepted the post of administrator at the Hotel Dieu Hospital in Cornwall, Ontario.

- L. A. Quaglia has been appointed assistant to the executive secretary of the Associated Hospitals of Alberta, Murray W. Ross. Mr. Quaglia has studied hospital administration at the University of Toronto and is a graduate of the 1956 class.

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• A chief auditor in charge of payments, rates and code, has been appointed to the Quebec Hospital Insurance Plan. He is Jean Jacques Minguy, former assistant manager at the St. Foy Hospital, Quebec.

• John M. Partlo, administrator of the Saguenay General Hospital, Arvida, Que., will, as of January 1, 1961, join the staff of the Queen Elizabeth Hospital in Montreal, Que. Mr. Partlo received his diploma in hospital administration from the University of Toronto in 1955.

• Dr. R. W. Pettigrew left the Essex County Sanatorium, Windsor, Ont., recently to study diagnostic radiology at Sunnybrook Hospital in Toronto, Ont. A specialist in diseases of the chest, Dr. Pettigrew arrived here from England in 1956.

• Former secretary at the Royal Edward Laurentian Hospital in Montreal, Que., R. A. Slute, has joined the Ontario Hospital Association as administrative assistant. William Phipps replaces Mr. Slute at the hospital.



• H. A. Connolly has been appointed administrator of the Haldimand War Memorial Hospital in Dunnville, Ontario. Prior to his new appointment, Mr. Connolly held the post of comptroller at the Victoria General Hospital in Winnipeg Man., for four and a half years Mr. Connolly is a 1959 graduate of the C.H.A. course in hospital organization and management.

• At the Essex County Sanatorium and I.O.D.E. Memorial Hospital Windsor, Ont., Mrs. J. Silinsky has been appointed director of nursing and Mrs. M. Drew as assistant director. Mrs. C. Catherine MacCormack, former superintendent of nursing, has accepted a similar appointment at the Sydenham District Hospital, Wallaceburg, Ont.

• Dr. John Silinsky, born in the White Russian colony of Shanghai has been appointed chief of the medical staff at Windsor's Riverview Hospital. Besides having worked in Quebec and Manitoba, Dr. Silinsky has also worked in Shanghai and other parts of China and for two years was a consultant to the United Nations Refugee Organization.

• Samuel Solomon, associate professor of biochemistry, and associate professor of experimental medicine, McGill University, was appointed to the newly created post of director of endocrine research, McGill Clinic, Royal Victoria Hospital, Montreal.

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**Dietary Service Institute**

The Quebec Hospital Association is sponsoring an institute on dietary service administration, December 6 and 7, at the Notre-Dame Hospital in Montreal, Quebec. The purpose of this institute is to review basic administrative principles and to explore the art of delegation, supervision and personnel management.

Margaret J. Ketchen will speak on "The rôle of the dietary department and of the director of dietetics"; Dr. A. Isabel MacArthur, "Future of the dietary service under hospital insurance"; and finally, Mrs. Margaret L. Mitchell, on "Food cost and quality control".

Further information may be obtained from the Quebec Hospital Association, P.O. Box 1025, Montreal, P.Q.

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The weary listlessness which renders life unsupportable to the voluptuous and the idolent is unknown to those who can employ themselves by reading.—*Fénélon*


# QUIET

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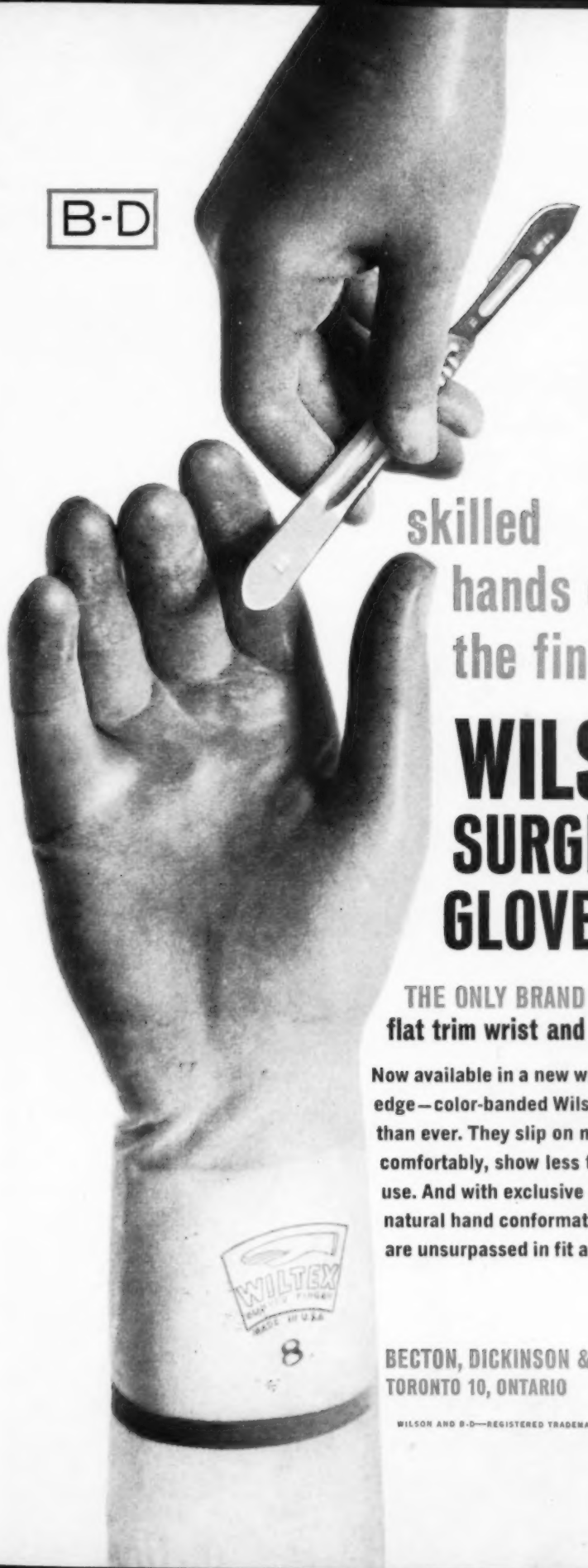


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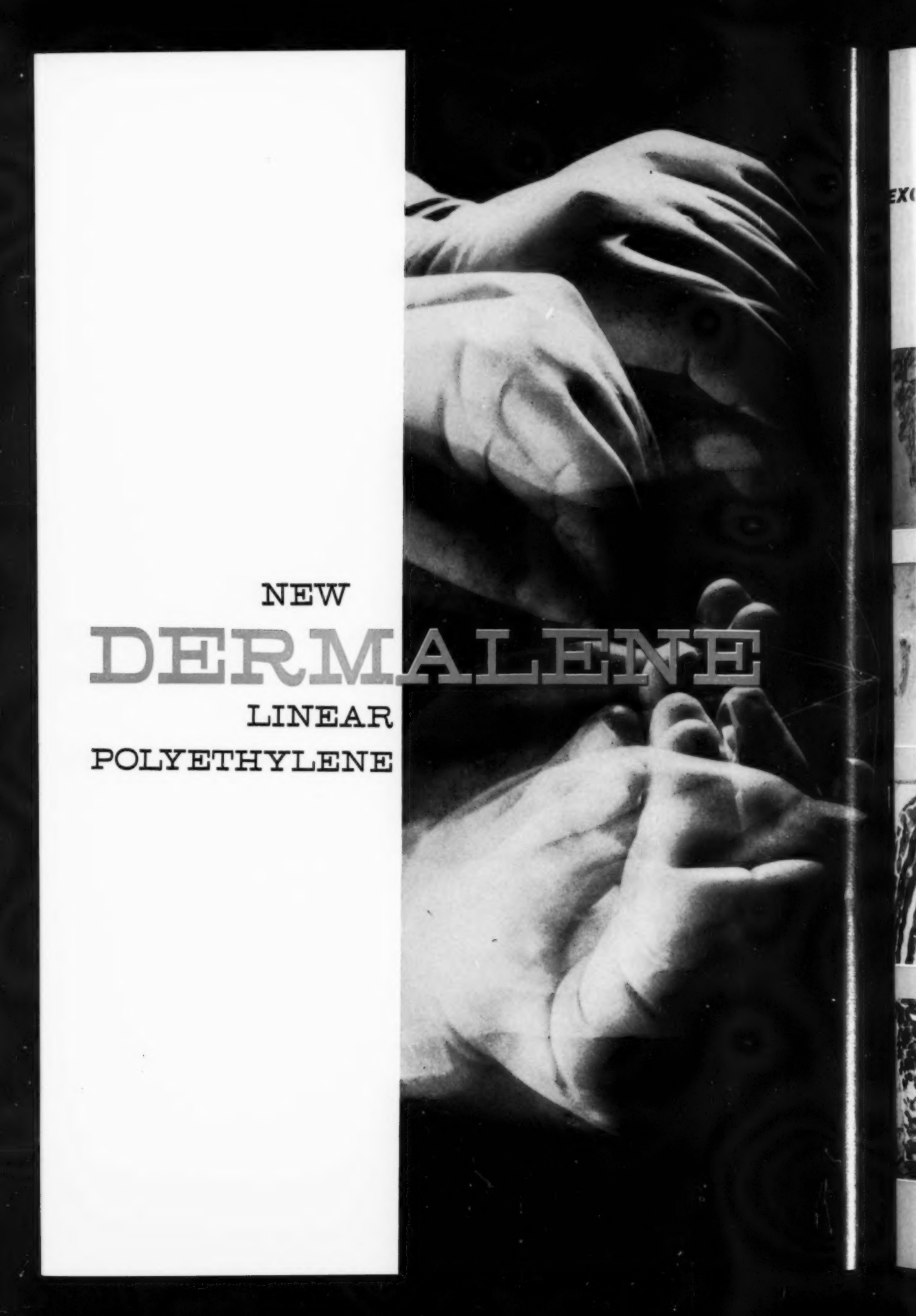
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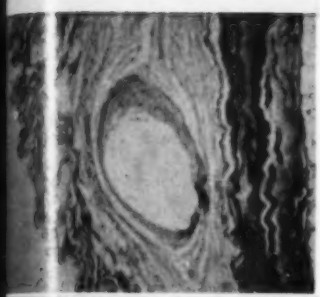
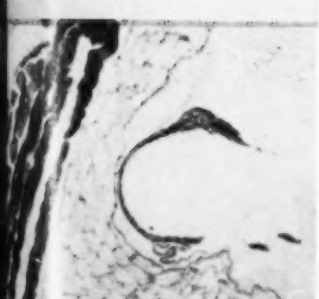


3-DAY EMBEDMENT

Note that other than slight edema very little tissue reaction is present. A few polymorphonuclear leucocytes and an occasional lymphocyte are seen.

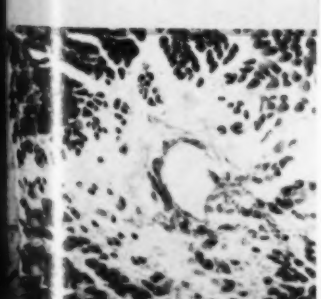
20-DAY EMBEDMENT

Fibrous capsule is developing. Other than slightly increased vascularity, no evidence of tissue reaction is evident.



2-MONTH EMBEDMENT

Thin dense fibrous capsule is present. No vascular reaction is observed and the number of fibroblasts is reduced.



6-MONTH EMBEDMENT

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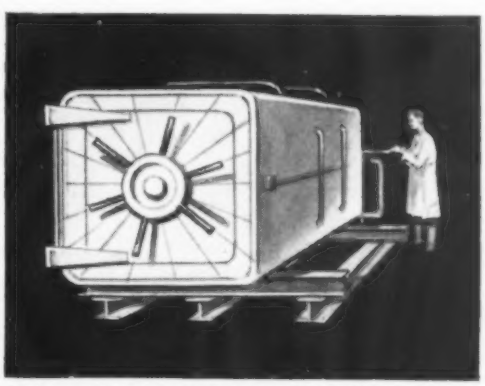

*1. Phelan, J.T.:* Surgery *45:674, April 1959. 2. Usher, F.C., and Wallace, S.A.:* A.M.A. Arch. Surg. *76:997, June 1958. 3. Koontz, A.R.; and Kimberly, R.C.:* Ann. Surg. *151:796, May 1960.*

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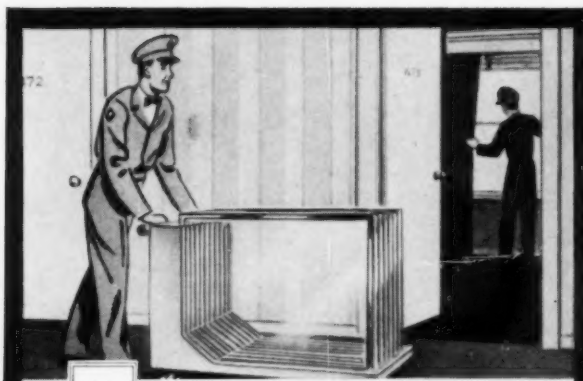

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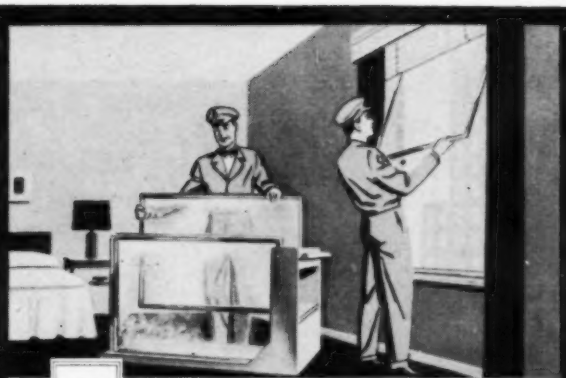

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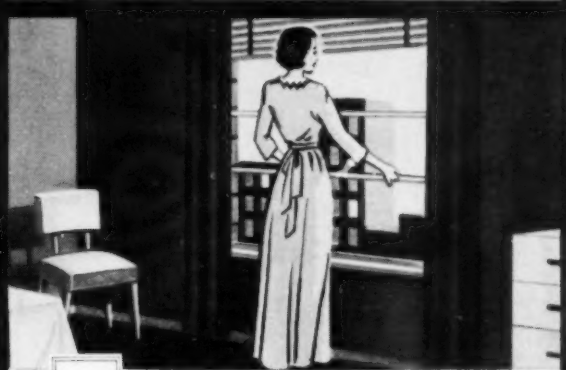

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# Christmas Greetings

**Stanley W. Martin**
**President**
**Canadian Hospital Association**

ONCE again the gaiety, the colour, the lightheartedness of men and women everywhere, the seemingly universal air of friendship and good will which pervades the world around us, each in its own way, herald the coming of yet another Christmas. Heart-warming and delightful to be sure, but transcending all of this is the spiritual comfort and peace granted each of us as we reflect silently on the true significance of this special anniversary, the birth of the Great Healer.

For those of us who are engaged directly or indirectly in the healing world of today, it is perhaps fitting that we should derive an extra measure of comfort from the fact that we, in all humility, are attempting to carry on a work which benefits those for whom He held such compassion.

As I have journeyed across this great country of ours and shared the hospitality of our good friends in the United States, I realize the tremendous amount of searching that is continuously going on amongst hospital people for better and more effective methods by which to discharge the great responsibility which is ours—the care of the sick and the injured. We must guard against any obscuring of our high purpose by materialistic considerations. That dollars and cents present a real problem cannot be denied, but at such a time as Christmas, we might pause again and reassess our true aims. May the results of our collective efforts reflect in a healthier, happier world in the years ahead.

As president of this association, it is my very special privilege to extend, on behalf of our board and staff, to our colleagues everywhere, our warmest Christmas greetings.

# Gleanings from History

**Angus C. McGugan,**
**M.D., D.P.H., F.A.C.H.A.**
**Edmonton, Alta.**

THE Province of Quebec is the cradle of hospitalization on the North American continent. Thoughtful, historically-informed, hospital personnel throughout the English-speaking world experience a deep sense of reverent gratitude to Normandy, especially to its port of Dieppe, and to Quebec for their contributions to the hospitalization of the sick throughout the centuries.

Prior to the nineteenth century, casualties among hospital personnel were higher than among the members of the armed services. Hospital personnel were drawn either from the ranks of devoutly devoted or the deteriorated desperate. Priests, monks, and sisters almost exclusively succored the sick during the first 15 centuries of the Christian era. With the Norman conquest of Anglo-Saxon England came the monks and the sisters on their missions of healing and mercy, and they founded such hospitals as St. Bartholomew's and St. Thomas'. For about the next 500 years they continued to serve the sick of England, until that momentous year 1534, when Henry the Eighth made himself head of the Church of England and dissolved the monasteries and suppressed the sisterhoods. It is significant that in the same year Jacques Cartier sailed up the St. Lawrence, visited the Indian villages of Stadacona and Hochelaga, and opened up a whole new field of service for missionaries and sisters. For about 300 years after the dissolution of the monasteries and suppression of the sisterhoods, England was dependent largely for her hospital personnel on prisoners discharged from jails, and on the poverty-stricken and hungry. With the era of Florence Nightingale, hospital personnel in England began to improve.

*The author is former administrator University of Alberta Hospital, Edmonton, Alta.*

Exactly 100 years after Cartier first sailed up the St. Lawrence, one of the first Jesuit missionaries to New France, Father Le Jeune, in 1634 made an appeal for a hospital to be established there. His plea reached the sympathetic ear of the Duchess d'Aiguillon, a niece of Cardinal Richelieu. She was a follower of Vincent de Paul (sainted in 1759), who founded the order called The Sisters of Charity. It was Vincent de Paul who, shortly before his death, stressed the necessity of obedience to the physician. The word "obedience" had the connotation "collaboration with" in the seventeenth century, just as it has today. The late Hon. Angus L. Macdonald, a former premier of Nova Scotia and a wartime member of the federal cabinet, used to say to his followers, "Trust the people. They will be wrong some of the time; but for the most part they will be right." May I borrow from that statement and offer a first bit of administrative philosophy: *Trust your medical advisors. They will be wrong occasionally; but for the most part they will be right.*

To those who visualize a Divine plan in the history of mankind and of nations, the Norman port of Dieppe presents a fascinating subject for contemplation. Henry the Second of England, one of the Tudor line of sovereigns, built the first castle there. It was given to the Archbishop of Rouen by Richard Coeur-de-lion. Throughout the centuries Dieppe fought with and against the English. In recent years, Canadian blood bought back Dieppe for the French. From Dieppe the Augustinian Hospitallers had succored the wounded, the pest-stricken, and the famine-stricken of continental Europe from the earliest centuries of Christendom, as France, and particularly Normandy, has been the historical battleground of Europe for the past two thousand years.

In 1639 there was great rivalry among the sisters of the order known as Hospitallers of the Mercy of Jesus (Hospitalières de la Miséricorde de Jésus) of Dieppe as to who should be chosen for the hospital (sponsored by the Duchess d'Aiguillon and under the patronage of Anne of Austria, Queen of France) in far-away New France—the Hôtel Dieu de Québec. The three sisters chosen were Marie Guenet de St. Ignace, Anne Lecointre de St. Bernard, and Marie Forestier de St. Bonaventure de Jésus. The oldest was 29; the youngest 22. They set sail from Dieppe on May the fourth and arrived at their destination on August the first. They braved all the terrors of the unknown. They encountered adverse winds, made a wide detour to avoid an enemy squadron, narrowly escaped collision with an iceberg, and finally were welcomed at Quebec by the Governor de Montmagny. They slept their first night in New France in an unfinished warehouse. Their mattresses were boughs crawling with caterpillars.

Their patients flocked to them a few hours after their arrival. The heat of August was almost unbearable. Food was scarce, and so great was the fear of contagion among the laity that the sisters were obliged to do their own laundry at night while their patients slept.

The Hospitallers of the Mercy of Jesus based their Rules and Constitutions on the Rule of Saint Augustine compiled in the eleventh century from the writings of that saint. The Hospitallers of St. Joseph of La Flèche, who took over Jeanne

*(concluded on page 74)*

# Trustee Responsibility for

**W. I. Taylor, M.D.**
**Toronto, Ont.**

IN AN article published earlier this year*, we enquired into certain areas of trustee responsibility, and discussed the nature of some of the legal and moral aspects of trusteeship. Trustee responsibility for *medical* care of the patient in hospital was touched upon only briefly however.

The first question raised, of course, is whether trustees have in fact *any* responsibility for medical care. In many places medical care is thought of as being totally a medical staff responsibility. In others it is even thought of as being the sole responsibility of the patient's own attending physician. These misconceptions are found among both trustees and physicians, with unfortunate results for hospital patient care.

I quote from the talk I gave a year ago: "The board is responsible for appointing the medical staff and ensuring that each physician is qualified and competent to carry out the procedures he is permitted to undertake in the hospital. There is a misconception in many places that this is the responsibility of the medical staff. It is certainly a heavy responsibility of the staff by delegation, but it is primarily and ultimately a responsibility of the board. It is stated in the Standards in these words: 'the governing body of the hospital must obviously delegate the responsibility of medical functions to the medical staff, including recommendations as to the professional qualifications of all who practice in the hospital' and 'the medical staff is responsible to the patient and the governing body of the hospital for the quality of medical care rendered to patients in the hospital'. The medical staff is responsible to the board. The medical staff makes recommendations to the board but it is the board which must make appointments because the board is legally responsible for doing so."

I would refer you to an address given by Dr. Frederick Evis, a physician, lawyer and medico-legal consultant to the Ontario Hospital Services Commission, to the Ontario Hospital Association Convention in October 1957. The address was published in the July to October 1958 issues of *Canadian Hospital*. Doctor Evis points out that court rulings have unquestionably established that the hospital board of governors, by virtue of its responsibility for government and managment of the hospital, has full responsibility for hospital operation and full authority over hospital personnel, including the medical staff; that it has the right to require every applicant physician to submit evidence of his credentials; that it has the right to appoint physicians to the staff and grant privileges accordingly, and the right to refuse medical staff privileges and to withdraw privileges previously granted to any physician who does not satisfy legal requirements which the board is entitled to make.

These powers are not only rights, they are duties of the board of trustees. The board is responsible and may be held liable for not having exercised due care if it permits physicians to admit and treat patients in the hospital unless those physicians have been properly appointed and their privileges allocated.

Both Dr. Evis and Dr. M. T. MacEachern, in *Hospital Organization and Management*, are careful to point out that a license to practise medicine does not *per se* give a physician the privilege of admitting his patients to a hospital or grant him use of the hospital's facilities or equipment—that a *hospital appointment is a privilege and not a right*. Both also specifically refer to the number of court cases which have upheld the principle that it is not considered illegal discrimination if, from a number of physicians in an area, a hospital selects members of its medical staff with regard not only to their medical skill and knowledge but to their adaptability to the rules and disciplines of the hospital.

It is the board's responsibility to appoint a medical staff who are qualified, competent and worthy, but their responsibility does not end there. It is the board's responsibility to determine the standards of patient care. There is a misconception about this also: and the concomitant misconception that the board, consisting largely or entirely of laymen, is not competent to assume this responsibility.

### Standard of Care

It should be self-evident that lay members of a hospital's governing board are not competent to judge *quality* of medical care, but let there be no question that the board has both the ability and the authority to dictate the standard of care which is provided in their hospital.

How can trustees undertake this responsibility? We in the accreditation program suggest that the answer is found in the *Standards*, *Methods of Procedure*, and other official documents published in this country by the Canadian Council on Hospital Accreditation and in the United States by the Joint Commission on Accreditation of Hospitals. If a hospital has a certificate of accreditation, the board has some reasonable assurance that at least minimum standards are being met. They have the further assurance that the accreditation program will make periodic review of the conduct of the hospital every three years or so, and that after every survey visit additional recommendations for further improvement in the quality of pa

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*The author is executive director of the Canadian Council on Hospital Accreditation. From an address presented at the Ontario Hospital Association annual convention, October, 1960.*

**Canadian Hospital, May, pp. 37.*

# Medical Care

ient care in that hospital will be made. The accreditation program then does provide a board of trustees with valuable yardsticks by which to determine whether minimal standards of patient care are being maintained.

Before we consider medical care as such, we must recognize that medical care is given in what is, for the doctors, a more or less predetermined hospital environment. Unless that environment is suitable, no efforts on the part of a good medical staff can succeed in giving high quality care to the patients who are hospitalized there. The first responsibility of trustees, then, is to provide a physical environment which is conducive to good patient care. In the words of the *Standards*, the physical plant should be "constructed and arranged to ensure the safety of the patient and promote his welfare." When we think of patient safety, we should think first of fire and infection. If the hospital is going to be a safe place to give medical care, it certainly must be free from these hazards. The safety of the patient must be no minor board consideration.

In addition to its being safe, the *Standards* say the physical plant should "promote the patient's welfare." This means that the board cannot merely be content with assuring that patient suffers no hazards to his health in the hospital in addition to those he brings with him. The board must take no such negative approach. There are positive steps which will promote the patient's early and complete recovery. The place must be clean. Some parts of it must be sterile or nearly so. Quietness is important. Patients' rooms should be comfortable and with quiet decoration. These aspects of care should pertain in your hospital, not because you are competing with the atmosphere or service in a hotel, or rest home, or even another hospital—but simply because the kind of physical plant you provide does indeed affect the rate and degree of patients' recovery. It is a necessary basic foundation of the environment you provide for medical care.

Having supplied a safe physical plant which will contribute to the patients' welfare, your responsibility for medical care has not ended. There are other, even more important environmental factors. These we would list briefly as things and people—but more often they are described as services and administration. You must be sure that the hospital can give the services needed for good medical care. You must, therefore, assure good administration and to do that you need a good hospital administrator, and the hospital-type hierarchy working through him to you. He is your official representative. Through him, your authority and responsibility are channeled. Under him the hospital people must be properly organized, directed and supervised to give the service a good hospital staff should, in order to make good medical care possible.

### Essential Services

There are certain hospital services which the accreditation program says are essential. You must assure a good dietary service, not only to provide therapeutic diets which nowadays will have to be supplied for anywhere from 20 to 35 per cent of the hospital population at any given time, but to assure that all meals are appropriate to patients' needs as ordered by the physician. The food should be good, and the service should be good also. You must supply drugs and other therapeutic agents and be sure *what* is needed will be there *when* it is needed. You should provide x-ray and pathology and clinical laboratory services, so that the doctors may undertake the tests necessary for accurate diagnoses and provide proper follow-up care. You need to provide a good medical records library and a properly qualified librarian in charge of it. There should be an adequate medical reference library. And very important, also, are properly equipped services for operations, for delivery of maternity patients, for care of the newborn, for post anaesthetic recovery and for emergencies.

Further, you must provide competent nursing service, to assure that there is professional nursing care available for all patients at all times. Essential, too, are other ancillary professional and technical personnel, the tools these personnel need and the space in which they can work, appropriate to the needs of your hospital. Physiotherapists, occupational therapists, chemists, physicists, social workers and a host of others are needed nowadays. Then, having done all that, you must make sure there is good direction and supervision of each unit and effective liaison and coordination among them so that all will work together to provide the proper staff and facilities needed for good medical care. You thus provide the atmosphere in which the best medical care can be given—but it must be vitalized by a medical staff.

### Medical Staff Organization

When you have appointed a medical staff who are qualified, competent and worthy, it is your responsibility to see that they are properly organized. An approved pattern for medical staff organization is outlined by the accreditation program in some detail in the *Suggestions for Medical Staff By-laws, Rules and Regulations*. There is stated the accreditation program's concept of how to run the medical staff. The answer is you don't! "The medical staff is self-governing". I appreciate that as soon as we make that statement, we run into a host of enquiries. How can you have effective govern-

*(continued on page 64)*

# ACTIVATION PROGRAM

## for the chronically ill

**L. F. Detwiller,**
**M.A., M.H.A., M.R.S.H.,**
**Victoria, B.C.**

THE type of coverage originally provided through the British Columbia Hospital Insurance Service (B.C.H.I.S.) was designed to meet the needs of the acutely ill in that province. While the program included coverage of the acute phase of chronic care, it did not include the longer period of the "chronic" or the rehabilitation stage of illness. However, as the needs of the acute care group were gradually taken care of, pressures began to arise for the development of a coverage program for patients suffering from chronic or long-term illness. These pressures came from many sections of the community, with the result that lay and professional groups, interested in this type of care, made representations, both at local and provincial levels, to have some sort of coverage program implemented.

In recent years, the acute care hospitals in the province have been faced with an increasing problem of having some of their beds occupied by long-term cases. This situation has developed partly because of the lack of proper facilities to which patients in the general hospitals could be discharged after the acute phase of their illness had passed. As a result, chronically ill patients have, in some instances, continued to occupy beds in acute hospitals, making it increasingly difficult to obtain a bed for the acutely ill patient. It is quite possible that this situation may have brought about the construction of more beds for acute illness than might have been the case if a properly orientated chronic care program had been in operation from the inception of the hospital insurance plan.

In January, 1957, the government presented a proposal to interested groups for a Chronic Treatment and Convalescent Coverage Program, emphasizing the need for both facilities and personnel to implement such a scheme.

There were four problems to be solved in the introduction of the program: the provision of adequate chronic care facilities; the type of services to be covered; the manner in which these were to be provided through the hospitals; and the personnel required to administer the program. In the case of the former, it seemed logical that construction of the rehabilitation hospital should follow the precedent that had been set in the case of the acutely ill patients, where the facilities are provided by the community, with assistance from the provincial and federal governments.

In order to encourage the construction of facilities, the government urged municipal and community organizations to construct and equip hospital units, as required, throughout the province for the full development of the program. The provincial government committed itself to assume 50 per cent of the approved cost of construction and, in addition, would pay one-third of the cost of depreciable equipment. Unfortunately, to date, construction of these units has not progressed as rapidly as was hoped —possibly because so many communities were still concerned with the development of their general hospital facilities.

With the announcement that The Rehabilitation, Chronic Treatment and Convalescent Care Plan would commence on September 1, 1960, certain hospitals were selected as centres in which coverage would be provided; and patients qualifying on medical grounds are now eligible for coverage in the following facilities: G. F. Strong Rehabilitation Centre, Vancouver; Gorge Road Hospital, Victoria; Holy Family Hospital, Vancouver; Queen Alexandra Solarium for Crippled Children, Victoria; and Poliomyelitis Pavilion of the Pearson Hospital, Vancouver.

In addition, coverage is provided in the veterans' hospitals in Vancouver and Victoria for patients entitled to B.C.H.I.S. coverage in those hospitals. It is expected that when the new Lions Gate Hospital in North Vancouver is completed, the present North Vancouver General Hospital (in part, if not in full) will be renovated to provide rehabilitation, chronic treatment and convalescent facilities for the people of Greater Vancouver. In addition, as soon as the Nanaimo Regional Hospital is built, the present hospital buildings will, also, likely be available for the new program.

Discussions are being held with representatives of the Vancouver Preventorium and Mount St. Francis Infirmary in Nelson, in order to determine the measure to which these two institutions will participate in the program.

Due to the shortage of facilities throughout the province, it is necessary for the institutions slated for this program to make their services available to anyone, irrespective of the patient's home area. In effect, they must function provincially, rather than regionally. However, this is generally the manner in which public hospitals operate.

It is estimated that approximately one bed per 1,000 population is necessary for a program of this nature and, therefore, it will probably be necessary for some communities to join together with others in order that their regional requirements can be met.

To assist in this matter of regionalization, medical, financial

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*Presented at Vancouver Island Hospitals' Regional Council, Division of B.C. Hospitals' Association, October, 1960. The author is Assistant Deputy Minister of Hospital Insurance for British Columbia.*

and administrative representatives of the B.C.H.I.S. will visit those areas interested in the development of chronic care facilities. By surveying the needs of the area, together with its resources—both physical and professional, the surveyors will be in a position to make recommendations concerning the facilities required. The first such survey is under way.

### Type of Service

The type of rehabilitation services to be provided, and the manner in which they are to be administered through the hospitals, have been given considerable study, both by the B.C.H.I.S. and the appropriate medical authorities. Under the B.C.H.I.S. *the treatment of the patient is left to the medical profession.* This latter fact is very important and should be emphasized, since it is the declared policy of the B.C. government that, under the new plan, as with the present one, government will assist in the construction of the facility and the payment of coverage, but will again leave the treatment of the patient in the hands of the physicians.

Because of this and the obvious dependence of this program on the support and co-operation of practising doctors, it is interesting to note that the B.C. Division of the Canadian Medical Association went on record two years ago, supporting the 1957 proposal, and pointed out the necessity of establishing screening and assessment committees before any patient was admitted to one of the hospitals to receive coverage under the plan. They recommended that the rehabilitation portion of the program be supervised by a person with some training in this field, and that the plan be implemented on a small scale at first, so that a program of assessment and treatment could be worked out before the plan became province-wide. This is the manner in which the program is being developed at the present time.

In support of this concept, the B.C. Division of the C.M.A. and the faculty of medicine at the University of British Columbia have provided invaluable assistance regarding the requirements of the new plan. These two groups have arranged for the setting up of a study committee, which made possible full discussions between the B.C. Medical Association, the faculty of medicine, and the B.C.H.I.S. The continued advice and guidance of these important organizations will be most essential as the program progresses.

In the matter of qualified personnel, steps have been taken to establish a training program which will instruct present and new employees at the designated chronic hospitals in the treatment concepts to be followed in the future.

It should be noted that the development of the new program will not limit or change the policy of the B.C.H.I.S. of providing coverage in general hospitals for the period during that type of care. Coverage under the new program will be for patients who no longer require the intensive diagnostic and treatment services of an active treatment general hospital and who are certified by competent medical authority to be likely to benefit from rehabilitation treatments to the extent that they may be returned to their homes, and, if possible, to useful employment.

The classes of patients entitled to coverage are as follows:

(a) Those persons who will obviously benefit from rehabilitation procedures to the extent that they will be able to leave hospital.

(b) The test or observation group comprising patients who appear to be ones who can benefit by rehabilitation, but whose rehabilitation potential can be established only after a trial period of intensive rehabilitative treatment.

The basic medical concepts upon which these rehabilitation policies are being developed are somewhat of a departure from the usual type of medical care planning in this field. More emphasis is being laid on the psychological approach and the necessity for positive action on the part of the patient, so that he is continually being faced with new demands by way of treatment both physical and mental. Small, separate rooms, where peace and quietness have reigned supreme in the past, will be replaced with larger wards, filled with activity, so that the patient is continually taking part, or being instructed, in therapy treatment by watching the activity of others or by carrying out exercises himself. The keynote of the whole plan is to keep the patient active, and so achieve a rapid turnover of patients by rehabilitating them to their homes and work situations.

The well worn idea of long-term care, where everything possible is done to assist the patient and make him comfortable, is replaced by the concept of keeping him active, so that he helps to rehabilitate himself. All too often in the past, patients who could have been successfully rehabilitated, have been relegated to beds where they were pampered and protected, which was, in fact, the best way of making certain that they would never get out of bed again.

The program is not designed to include those patients who do not require the services and facilities of either an acute general or chronic treatment hospital or rehabilitative centre, but who can be adequately cared for in a nursing home or like institution. It is truly a rehabilitative program, dealing with a specific section of chronic care, rather than being a broad, generalized coverage. It is quite likely that, in the future, coverage may be extended to other levels of chronic care, but, because of the shortage of proper facilities and, especially, trained personnel, it has been deemed advisable to develop the chronic care scheme in stages, so that a properly balanced program can be developed for each level of care.

Coverage in an approved active treatment long-term hospital is available to persons who have resided in British Columbia for three months or more. Benefits are not provided outside the province. The cost to the patient is $1.00 per day.

Benefits for qualified residents admitted as in-patients are as follows:

(a) Public ward accommodation;

(b) Physiotherapy and occupational therapy;

(c) Such minor operating room facilities as are approved by the B.C.H.I.S.;

(d) Surgical and other dressings required in the daily care of the patients;

(e) Such cast materials as may be approved by the B.C.H.I.S.;

*(continued on page 80)*

# HOSPITALS *and their* COMMUNITIES *linked in service*

*Philip Rickard, administrator of the General Hospital of Port Arthur and Rupert Stocker, administrator, Victoria Public Hospital, Fredericton, N.B.*

*Dr. and Mrs. Harvey Agnew enjoying the sessions.*

OVER 3,000 eager delegates from hospital all across Ontario attended the 36th annual convention of the Ontario Hospital Association held at Toronto's spacious Royal York Hotel from October 24 to 26. Total registration was approximately 4000. "Linked in Service—Hospitals and Their Communities", the theme of the convention, emphasized the continuing need of community support for all hospitals in the province. In order to keep pace with ever increasing expansion programs, hospitals must depend on financial support from the communities they serve even more than before, if future needs are to be met.

In addition to the five general sessions, there were also 14 special sessions held, and delegates had an opportunity to visit the many exhibits displaying the latest in hospital equipment. Some of these sessions are reported on the following pages.

### Future Financing

The first general session, chaired by A. F. Fuerth, president of the O.H.A., was a symposium entitled, "Future Financing of Hospital Facilities". The topic was dealt with by three speakers, all of whom, in accordance with the theme of the convention, stressed the importance of establishing and maintaining a close link between hospitals and their communities. Dr. R. W. Ian Urquhart, chairman of the Ontario Hospital Services Commission, was the first speaker. Communities are often reluctant to pay their share of construction costs, in his opinion. Sometimes this reluctance is due to a lack of a proper sense of responsibility, on a regional basis, and sometimes to a community's desire to have its own hospital, he said. This desire was under a natural check before operating costs were taken over from the communities by the Hospital Services Commission. Now that operating costs are no longer paid by the community, there is a danger of building too many hospitals. In Alberta there are empty beds because hospitals exist in areas which cannot support them, he said.

In the past 13 years, the provincial government has made capital grants of $114,000,000, the federal government about $42,000,000 and the municipalities and the public have given $250,000,000 toward hospital building in the province. Citizens and municipalities gave almost one and a half times that provided by the two levels of government. This indicates the size of the people's stake in hospitals.

"Our hospitals are not government owned, but are part and parcel of the community in which they stand," he said. About 40 per cent of the capital cost of each hospital bed comes from the government, the other 60 per cent from private and municipal sources. There are still many areas where construction programs are lagging because funds necessary to supplement government grants are sadly lacking. If provincial and federal governments were to take over all capital costs, then priorities would be established by the governments and hospitals would lose their autonomy. This is the situation in England now, where priority given to road building is delaying hospital construction.

J. C. Saddington, C.A., reeve of Port Credit, Peel County, spoke on hospital financing from the municipal point of view. He explained the co-operation between the one town, four villages and five townships in this county to build a hospital through county issued debentures. For details of a recent by-law which governs hospital financing in Peel County see the *Canadian Hospital*, May, 196 page 35.

Today's citizens pay high taxes and have many payroll deductions and thus money for voluntary projects is not forthcoming as it once was. Provincial and federal governments should assume greater responsibilities or give the municip

### New President

*Mrs. J. A. Aylen*

*Two representatives from the St. Mary's Hospital, Timmins, Sister Denise Eva, superintendent and Sister Pauline Germaine, purchasing agent.*

*From the federal government—F/L G. O. Manderson, project officer and F/O G. C. Benjamin, stores officer, National Defence Medical Centre, Ottawa.*

*Carl I. Flath, F.A.C.H.A., principal, John G. Steinle and Associates, Garden City, N.Y. with Ivor H. Hunt, purchasing agent, Toronto East General Hospital in discussion after the meeting of the Purchasing Agents' Section.*

*Col. J. W. B. Barr, commanding officer of the Canadian Armed Forces Hospital in Kingston with Dr. W. E. Watson of Toronto East General Hospital.*

ities broader avenues of taxation. No matter how hospital financing is provided, hospital administration must remain in the hands of the local boards, said Mr. Saddington.

Daniel M. Sunday, vice-president and general manager for Ontario of the G. A. Brakeley and Company Ltd., spoke on private philanthropy in hospital financing. Almost all hospitals have to raise part of their money through a public campaign. Private philanthropy cannot take care of money not provided by government grants, and there is a ceiling to how much can come from the governments, said Mr. Sunday. He felt that a valuable by-product of a hospital campaign is the mobilization of united leadership of people representing all elements of the community — religious, economic and social—who are brought together in the hope of achieving one common goal. A public campaign, he said, will not only help to build a new hospital, but a new solid community spirit.

**Long-stay Patient**

The problem of the long-stay patient is becoming today more and more pressing and hospital people find it necessary to take active measures in dealing with this. This could be seen by the great number of interested delegates who attended the symposium on this subject.

The four speakers on the panel presented various views of the problems and some possible solutions to these. William A. Hume, administrator of Orillia Soldiers' Memorial Hospital, brought out the change that has taken place today in the attitude of modern society towards the person suffering from chronic illness. Society today is not generally willing to make the sacrifice for the care of the old and the ill. The time spent caring for an ill person would mean less time available for other activities of the family. Also the small suburban bungalow is not always suitable for the care of an ill person for a long period of time. Mr. Hume suggested that the Ontario hospital plan might be broadened to include custodial type of patients, and more money should be made available to municipalities to increase specialized facilities.

It was the general conclusion of all the speakers that shortage of beds for long-term patients does exist and that this shortage could be remedied partly by adding wings to general hospitals, converting unused beds like those in tuberculosis sanatoria, et cetera. Dr. R. S. Peat, consultant in program development, Ontario Hospital Services Commission, also stressed that in each community there should exist a balance among the various services provided, or shortage in one facility will increase the load on others.

The importance of having a social service department in the long-stay hospital was brought out by Sam Ruth, administrator, Baycrest Hospital, Toronto. The hospital should increase its discharges by emphasizing rehabilitation and planting in the patient's mind the idea of eventual improvement. The social worker can also relocate the patient to a nursing home or other suitable accommodation, once the patient does not require the continual care given in a hospital. The importance of differentiating between patients who require constant supervision in a hospital and patients who need only domiciliary care was underlined by Joseph Berkeley, M.D., specialist in physical medicine, Windsor. Because of this difficulty and many others, more training and understanding is required for the care of the long-stay patient at all levels — among the medical staff, nursing staff, and the community in general.

**Small Hospital Forum**

Hospital personnel from hospitals with beds numbering from 25 to 150, gathered to hear four speakers discuss the problems of the smaller hospital. These were reviewed from the standpoint of a trustee, an administrator, a member of a medical staff, and a director of nursing, representing small hospitals from various locations in the province. Dr. E. L. Crosby of Chicago, director and executive vice-president of the A.H.A., acted as chairman.

Carl J. Larsen, member of the board of trustees, County of Bruce General Hospital, Walkerton, impressed on the minds of the interested audience the necessity of continually placing the needs of the hospitals before the people of the community. With the advent of hospital insurance schemes, he foresaw the possibility of a certain amount of public apathy. He stated emphatically that this must not be allowed to happen. It is up to the trustees to educate the public. Two-thirds of construction costs must still be financed by the community, or else governments will have to take over the hospitals. In the end that would only mean higher taxes.

Small hospitals do not have small needs, stated George J. Riesz, administrator of Lady Minto Hospital, Chapleau. Mr. Riesz, in his very lively speech stressed the importance of public relations in helping to attract trained personnel to small hospitals where jobs are less specialized than in larger ones, thus offering unlimited challenges to the right person. In a small community, a useful form of public relations can be neighbourly gossip, but formal public relations through the media of radio, television and newspapers should not be neglected.

Dr. J. R. Holmes, vice-president of the medical staff at Sydenham District Hospital, Wallaceburg, saw the shortage of trained hospital staff and lack of money for adequate patient care as the chief problems facing the small hospital. A large part of the nursing staff consists of part-time or seasonal help, as the hospitals have difficulty in attracting trained nurses on a permanent basis. To provide a 24-hour emergency coverage for a hospital without a house staff is indeed a difficult task, Dr. Holmes pointed out.

Vera B. Eidt, director of nursing, Memorial Hospital, Campbellford, estimated that 41.7 per cent of her staff are trained on the job. These people require a great deal of supervision. The full-time nurse in small hospitals, who often must act in a supervisory capacity, has to have ingenuity, versatility and efficiency, Miss Eidt said.

A discussion period followed. Questions from the floor were answered by the speakers who were assisted in this part of the program by other qualified hospital people. George Morgan, accounting consultant of the O.H.A., in answering one of the questions, stated that as a result of a survey it was found that people on the whole do not understand the meaning of hospital insurance. Many people think hospital insurance pays for construction, et cetera. Public relations must include public education, he said.

*Reta Brown, director of nursing, South Peel Hospital, Cooksville with Pearl E. Morrison, administrator, The Queen Elizabeth Hospital, Toronto.*

*Enjoying a lighter moment at the convention are l. to r., Anthony F. Fuerth, president of the O.H.A., Dr. W. D. Piercey, executive director of the Canadian Hospital Association and Stanley W. Martin, executive secretary-treasurer of the O.H.A.*

*Chatting together are l. to r.: George E. Miller, purchasing agent, National Sanitarium Association with J. Douglas Snedden, comptroller, The Hospital for Sick Children, Toronto and Paul Shannon, comptroller, Royal Victoria Hospital, Montreal.*

**Purchasing Agents' Meeting**

This year, hospital purchasing agents held their first meeting as an organized section of the O.H.A. George Miller of the National Sanitarium Association presided and to the large audience he explained the work of the interim officers leading to formal organization. A constitution and by-laws for the section were presented and adopted. Officers elected for 1960-61 are as follows: *chairman*, Ronald Baker, Hamilton General Hospitals; *vice-chairman*, Garnet Stark, Ottawa General Hospital; and *secretary*, John D. Ingham, Humber Memorial Hospital, Toronto.

At this inaugural meeting, the guest speaker was Carl Flath, F.A.C.H.A., principal, John G. Steinle and Associates. A former Canadian and some 20 years ago administrator of Wellesley Hospital in Toronto, Mr. Flath recalled his early experience as a supply house salesman in this country, then as a hospital purchasing agent, and as an administrator. Throughout his address he stressed that good purchasing practice affects every section of the hospital. As the result of a survey of 50 administrators and as many supply houses, he was able to report that the two characteristics of a purchasing agent deemed more important than all others are *integrity* and *courtesy*. Knowledge of products and judgment in buying came third and fourth in the majority of replies, he said. Mr. Flath deplored the term purchasing agent (an agent sells tickets) and he suggested that the title "director of purchasing" would help to upgrade what is actually a very responsible position. He said, too, that purchasing agents who handle thousands of dollars in public money should be so well paid that there is no temptation to accept payola. The integrity of the hospital buyer must be above question—(when passing through a melon patch he cannot afford to tie his shoe).

Mr. Flath stressed the importance, to the purchasing agent, of reading constantly and widely in order to increase his general knowledge as well as keeping abreast of his own field. He must also, the speaker said, develop to a high degree, the art of listening. He suggested that purchasing agents as a group, should produce a monthly digest or bulletin to which each member would be required to contribute at least once a year. Mr. Flath emphasized the need for continuing education and suggested

formal and informal means to that end.

At a panel discussion, under the chairmanship of C. D. Wickenden, Toronto East General Hospital, questions came from the floor in rapid succession and interest was intense—even among the many who had to stand.

**Engineering Section**

This section, which held its inaugural meeting in 1959, now has a membership of 110, representing 87 hospitals in the province. In his opening address, the chairman, Frank Benvenete of St. Michael's Hospital, Toronto, acknowledged the unlimited assistance given to this group by officers of the parent body, O.H.A. He stressed the importance of a competent engineer in helping to lower hospital operating costs. Mr. Benvenete referred to the very successful institute held earlier this year (see *Canadian Hospital*, June 1960) and discussed possible future activities.

The major portion of this meeting's program was devoted to a workshop. Members were divided into groups, each headed by a member of the executive; and problems selected from a survey were discussed. Later, the findings of each group were reported, and in this way the large gathering was given a consensus of opinion of the many problems analyzed.

Following the program, a business meeting was held during which time a discussion took place on the set-up of a three-day institute to be held next April in Toronto, to promote the improvement of hospital engineering services.

The motion that the present executive be returned to office was carried. The officers are as follows: *chairman*, Francis R. Benvenete, St. Michael's Hospital, Toronto; *vice-chairman*, G. C. Stevenson, Toronto East General Hospital; *secretary*, H. J. Cunningham, St. Michael's Hospital, Toronto; *public relations officer*, W. J. Longeway. Queen Elizabeth Hospital, Toronto.

*Aerial view of some of the exhibit booths in the new Canadian Room at the Royal York Hotel.*

**Housekeepers' Section**

An eager audience of housekeepers filled one of the convention rooms to hear Sister St. Oswald give her secretarial report. She happily reported that there has been a definite attempt made to provide hospitals with trained housekeepers, and that a committee on education is studying the problem. The program was under the chairmanship of Bram Allington, chief housekeeper at Hamilton General Hospitals.

The remaining part of the meeting was devoted to selected aspects of hospital housekeeping. W. A. Jones of Abell Waco Ltd. provided many helpful hints to housekeepers in his illustrated talk on pest control. Pests exist, he pointed out, wherever the decomposition of organic matter exists. Empty soft drink bottles, stale biscuits, old cartons that had been used to deliver fruit and vegetables, dishwashing rooms, and other moist basin areas are all ideal breeding places for pests. Extermination is complicated by two factors—their rapid breeding habits and their ability to build up an immunity to chemicals. Wherever possible, he suggested, metal instead of wood should be used in the original construction. Pest control is the first step in good housekeeping, but if it gets out of hand the best thing to do is to turn the problem over to trained personnel, was Mr. Jones' closing advice to the housekeepers.

A. S. Brown, chief accountant of the Toronto East General and

*(continued on page 60)*

*Dr. J. J. Laurier, (left) Ottawa General Hospital, with Father Bertrand, s.j., executive director, Comité des Hôpitaux du Québec and Dr. E. L. Crosby.*

*Delegates to the convention from The Mountain Sanatorium, Hamilton, l. to r. Constance Davis, therapeutic dietitian, Mary McCroy, housekeeper and Marion Evans, dietitian.*

**9th Manitoba Hospital and Nursing Conference**

# Practical Problem Solving

*Dr. L. O. Bradley, administrator, Winnipeg General Hospital, addressing a session. Other members of the panel are the Hon. George Johnson, Minister of Health and Rev. Eric Sigmar, president, Winnipeg Ministerial Association.*

**Concurrent Sessions**

- **trustees**
- **administrators and administrative personnel**
- **purchasing agents**
- **nurses**
- **auxiliaries**
- **public health**
- **laboratory technicians**
- **physiotherapists**
- **social workers**
- **dietitians**
- **medical record librarians**
- **pharmacists**

THE theme of this convention, with its many facets, was "Today's Problems in Hospitals." In his presidential address, Dr. L. O. Bradley, listed a number of these problems and told what had been done by the Associated Hospitals of Manitoba in an effort to solve them. In addition, he stated that the work of the association was increasing, since the hospitals themselves wanted more advice and assistance from their association.

Dr. Bradley stressed that the responsibility for the autonomy of the hospital lay in the hands of the trustees, the employed hospital staff, the medical staff and the community itself. Even though government agencies have shown no desire to assume control of hospitals, he said, this responsibility will, of necessity, be assumed by them if it is neglected by the voluntary agencies to whom it is now entrusted.

The keynote address by S. W. Martin, president of the Canadian

**George McCracken**

Hospital Association, set the scene for later discussions. The entire three-day conference was devoted to the problems facing the hospitals of today and their practical solution.

Altogether 13 organizations met concurrently and delegates to all were welcomed at general sessions. Total registration was well over 1200. In this brief report it is possible to touch upon only a few of the questions raised in the many lively sessions.

**George Findlay Stephens Award**

A respite from hospital problems was given the assembled delegates at the conference banquet. One of the highlights of the banquet was the presentation of the above award to Judge John Milton George, Morden, for his long and devoted service to hospitals in Canada. (See *Canadian Hospital*, July, 1960, page 28.)

*Judge George*

**Contracts**

Some of the legal aspects of purchasing were pointed out to delegates by R. D. Guy, Q.C., who stated that there are five elements to a contract—the offer and acceptance; the form or consideration; the capacity of parties; the reality of consent; and the legality of object. He stated that an offer is made when it is communicated to the offeree and a revocation of the offer must reach the person to whom it is offered before it is accepted, since an offer once accepted is irrevocable. However, the acceptance of the offer must be made in the same terms as the offer itself.

Mr. Guy stated further that it is necessary to be careful when dealing with minors and companies, particularly in relation to companies which can only do what their charter says they can do. It is also necessary, when dealing with an individual of a company, that the purchasing agent should be sure the individual has the required authority to sign a binding contract.

Mr. Guy closed his address with the following comments on the legality of object. This means that a contract may not be entered into if the purposes of the contract are against the law. Although it is considered that all people know all law, which is usually expressed in the statement "ignorance is no excuse", there may be innocent misrepresentation which can nullify a contract. Further, there is willful misrepresentation—however, this borders on fraud. In order to prove fraud, it is necessary to prove: (1) that the other party made a misrepresentation of fact; (2) that this misrepresentation was indeed

a fact and not of purpose; (3) that this representation was wrong; (4) that it was done wilfully or wrecklessly; and (5) as a result of this misrepresentation, the action was taken and the consequences suffered.

**Problems in Purchasing**

Ethics, according to H. D. Knox, purchasing agent, University of Manitoba, should be considered in relation to management, suppliers and ourselves.

In relation to management, it is necessary to maintain a constant supervision of the purchasing policy in order to prevent unnecessary purchasing and allow for changing conditions. This involves a need for an efficient re-order system to see that supplies are on hand when needed; and the purchasing agent should constantly be aware of the need for co-operation with other departments of the hospital.

In relation to suppliers, it is encumbent upon the purchasing agent to make the hospital business as attractive as possible to suppliers. By keeping many suppliers interested in your business, you stimulate competition and thereby attain the best possible prices for your hospital. It is advisable that the purchasing agent make every attempt to keep appointments, to consider good service as well as prices when assessing bids, and to keep all quotations secret.

In relation to the individual, ethics and personal integrity are as one. In the matter of gifts, Mr. Knox felt that anything the purchasing agent would be willing to show as a matter of course, such as pencils or notebooks, would be acceptable advertising souvenirs. Anything which the purchasing agent would not wish to make public could only be termed a bribe.

In addition, the purchasing agent has the responsibility to himself and to his job to keep abreast of changes in the field; this means that it is encumbent upon him to visit suppliers and the markets in order to be aware of current trends.

**Problems in Pharmacy**

This was a panel presentation and discussion centred on what the small hospital can do to have its pharmacy supervised by a registered pharmacist even though, because of size, it may not be able to afford the services of a full-time pharmacist. The moderator of the panel, R. Publow, consulting pharmacist, Standards Division, Manitoba Hospital Services Plan, suggested three methods of obtaining pharmacy service in the small hospital. These are (a) hire a pharmacist who combines his profession with other duties, such as purchasing; (b) a pharmacist to serve more than one hospital; (c) a local pharmacist on a part-time basis.

Miss J. Giesbrecht, superintendent of nurses, Bethesda Hospital, Steinbach, pointed out that when a nurse looks after the pharmacy she spends much time doing work for which she is not trained and her time would be better spent in nursing. Further, there is a danger in having an untrained person dispensing drugs. Moverover a pharmacist, as such, has an educational value to the nursing staff.

C. Oliver, president, Manitoba Pharmaceutical Association, Portage la Prairie, reported that, according to a recent survey, there is only one pharmacist in Manitoba assisting a hospital on a voluntary basis and this person does not help in buying supplies for the hospital. Mr. Oliver stated, as did Miss Giesbrecht, that the pharmacist, by training, would be a valuable assistant to the hospital, particularly in purchasing.

George Swan, administrator, Morden District Hospital, Morden, stated that there are two parts to the problem—what the administrator needs, and his method of obtaining it. Mr. Swan said that at present administrators are unhappy because in many cases they are not abiding by the Pharmaceutical Act. He also stated that the most important step in drug control is on the nursing ward and that it is as important to have professional help here as it is in the storeroom. He further mentioned that the pharamacist can by virtue of his training assist and advise the doctor on economical means of purchasing drugs better than anyone else in the hospital.

The decision of the panel was that regardless of the size of the hospital, a registered pharmacist is justified. Although it may be difficult for the part-time pharmacist to attend the hospital, since by law he is compelled to be on the premises of his store during store hours and, although it is preferable that a pharmacist should not do hospital work without some formal training in this field, nevertheless, by using one of the methods suggested, every hospital, regardless of size, should be able to have the services of a qualified pharmacist.

*(concluded on page 46)*

**Executive Committee for 1960-61**

*Front row left to right: Miss M. Dunn, Hamiota District Hospital, Hamiota; R. J. Hood, Fox Memorial Hospital, Carberry, second vice-president of the association; W. T. Andrew, Hamiota District Hospital, president; G. B. Rosenfeld, Victoria General Hospital, Winnipeg, first vice-president; and H. A. Crewson, executive secretary. Back row left to right: W. W. Devine, Portage District Hospital, Portage la Prairie; F. W. Buchanan, Children's Hospital of Winnipeg; Major S. Mundy, Grace Hospital, Winnipeg; J. Gardner, Dauphin General Hospital, Dauphin; E. Dubinski, Sanatorium Board of Manitoba; D. McIvor, Selkirk General Hospital, Selkirk; and A. K. McTaggart, Brandon General Hospital, Brandon.*

*Missing from the picture are the following: Dr. L. O. Bradley, Winnipeg General Hospital, immediate past-president; Dr. P. L'Heureux, St. Boniface Hospital, Winnipeg, honorary secretary-treasurer; H. Posniak, Misericordia General Hospital, Winnipeg; and Dr. John Szmetana, Riverdale Hospital, Rivers.*

# STANDARDS STRESSED

## by associated hospitals of alberta

*Scene from one of the general sessio*

SISTER MARY, administrator of St. Joseph's Hospital, Barrhead, was elected president of the Associated Hospitals of Alberta on the occasion of the 17th annual convention, held at Edmonton, October 25-27, 1960. Exceptionally fine fall weather, undoubtedly, was a factor in making it easier for delegates to attend in large numbers and a new record for registration was set. The spacious Jubilee Auditorium provided excellent facilities.

William Chessor, chairman of the board of Lacombe Municipal Hospital and a past president of the Associated Hospitals of Alberta was presented with a citation on the occasion of the convention banquet. The citation, which was read by Chief Judge Nelles V. Buchanan, outlined Mr. Chessor's varied services to the hospitals of Alberta over a period of many years.

**W. Douglas Piercey, M.D.**

A session entitled "What's Your Beef?", under the chairmanship of Murray Ross, the association's energetic executive director, was most interesting. Here all delegates were given an opportunity to air their pet grievances or express their views in short presentations. The mobile microphone was kept very busy and, as ample time was allotted on the program, every one was allowed his or her full say. The session was primarily a very active question and answer period and proved most useful.

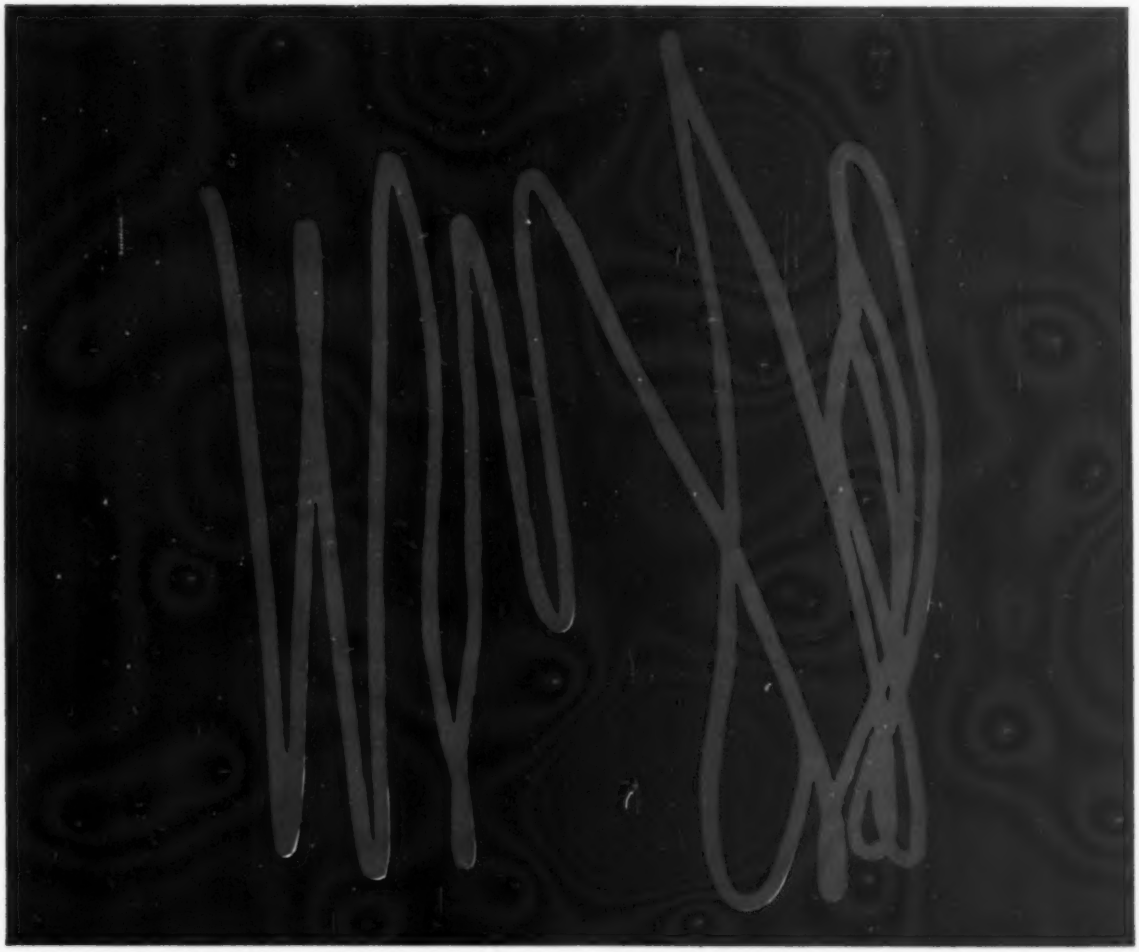
The subject of hospital standards occupied much of one day. Rev. H. L. Bertrand, s.j., director of the Comité des Hôpitaux du Québec, set the stage with an address entitled, "Who Sets Standards?" (see *Canadian Hospital*, November, 1960, page 58). Father Bertrand was followed by Dr. J. C. Johnston, administrator of the Calgary General Hospital, who spoke on the topic, "How Are Standards Maintained?" The executive director of the Canadian Hospital Association then discussed "What Has Been Done About Standards In Canada?"

An interim report on the survey of standards of nursing care in Alberta was presented by Dr. J. C. Wallace, director, Hospitals Division, Department of Public Health of Alberta and Ruth McClure, director of the School of Nursing, University of Alberta spoke on "Present Standards of Training: Degree and Diploma Courses". Madeline I. Quirk, director of nurse recruitment and registrar-consultant, School for Nursing Aids, Calgary, outlined "Present Standards of Training for Auxiliary Nursing Personnel."

A panel discussion on nursing

*(concluded on page 46)*

*The new board of directors, back row l. to r., Dr. J. C. Johnston, Calgary; B. Liland, Sexsmith; Sr. Mary Clare, Camrose; Sr. Alice Gauthier, Edmonton; Dr. D. R. Easton, Edmonton; J. Cramer, Michichi; and S. V. Pryce, Calgary. Front row: F. W. Lamb, Lethbridge, treasurer; J. E. Carlson, Champion, first vice-president; Sr. Mary, Barrhead, president; Chief Judge Nelles V. Buchanan, Edmonton, past president; and L. R. Adshead, Edmonton, second vice-president; Not present, Stewart M. Chapman, Lethbridge and the hon. president Hon. J. Donovan Ross, M.D.*



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*Chief Judge Buchanan and William Chessor, past president of the association, during the presentation of a citation to Mr. Chessor.*

service and education was held. Participants were: Hon. J. Donovan Ross, M.D., Minister of Health for Alberta, Eileen Jameson of the Calgary General Hospital, Dr. D. R. Easton, administrator of the Royal Alexandra Hospital, Edmonton, S. K. Hummel, administrator, Columbia Hospital, Milwaukee, Wisc., and speakers from the panel on standards.

Accreditation of nursing schools was presented under two headings: (a) "Trends in Canada" by Dr. W. D. Piercey, outlining the philosophy behind the project for the evaluation of nursing schools recently completed by the Canadian Nurses' Association; and (b) S. K. Hummel reviewed the situation in the United States under the heading "If We Were Doing It Again".

Dr. W. I. Taylor, director of the Canadian Council on Hospital Accreditation, continued the subject of standards as it is related to standards of medical care. Dr. Bernard Snell, medical superintendent of the University of Alberta Hospital, then spoke on "Organization and Government of the Medical Staff".

The Hon. Dr. J. D. Ross gave details of the model by-laws for the medical staff for small hospitals which the department had developed for the guidance of small hospitals in Alberta. The Minister's presentation was followed by an active question and answer period.

The first day was set aside for business sessions and the presidential address was given by Chief Judge Nelles V. Buchanan. Then came reports by the treasurer, L. R. Adshead, administrator of the University Hospital, Edmonton; the report of the Alberta Blue Cross Plan by J. A. Monaghan, executive director; and the executive secretary's report by Murray W. Ross. An informative booklet containing reports of various committees of the association, which was distributed to the delegates, speeded up the discussions of the association.

Several concurrent meetings were held. These included meetings for trustees; matrons; secretary treasurers; hospitals of 180 beds and over; committee on chronic hospitals; the Associated Auxiliaries of the Hospitals of Alberta; Alberta Association of Hospital Administrators and Secretary-Treasurers; and Institutional Laundry Managers. Delegates had an opportunity of hearing the regimental band of the Coldstream Guards and the Pipes, Drums, and Dancers of the Queen's Own Cameron Highlanders.

Some 18 resolutions were presented to the delegates and some provided lively discussion. These will appear in the January issue. ■

*Board of trustees of the Alberta Blue Cross Plan, back row l. to r.: L. R. Adshead, Edmonton; G. S. MacKenzie, Calgary; J. E. Carlson, Champion; and F. W. Lamb, Lethbridge. Front row: Sr. Mary, Barrhead; Chief Judge N. V. Buchanan, Edmonton, chairman; and Sr. Mary Adele, Camrose.*

**Manitoba Conference**

*(concluded from page 43)*

**Employee Unions**

Steward Martin, Ph.D., LL.B., discussed for some time the legislation which has been formulated to foster collective bargaining and remarked that this legislation is designed to provide a framework within which collective bargaining may be done. The speaker then went on to point out some of the practical problems of union negotiation. He stated that such negotiation is a business and that union officers are trained and, therefore, it is encumbent upon hospital officials to have at least equal training. Dr. Martin stated that it is the duty of the hospital board to avail themselves of competent help during negotiation.

In the discussion period Dr. Martin suggested that, in the small hospital, an appeal to neighbouring industry might be worthwhile and that in union negotiation the full board should not be used. Also, it is not wise to give the bargaining committee the authority to make a final decision. Referring back to a final authority provides time for study of the proposal offered.

**Government Problems**

The speaker, G. L. Pickering, Commissioner, Manitoba Hospital Services Commission, stated that there are two types of problems: (1) the problem of administrative technique and (2) the more major and basic problems of providing total hospital care. Mr. Pickering concentrated on the second type. He stressed, first of all, the problem of government-hospital relations. He remarked that a degree of success in solving these has been achieved and that further success would depend on two factors—(a) the ability to define areas of responsibility and (b) the willingness of each party to meet its own responsibility. Mr. Pickering stated that the hospital is no longer a luxury but a deserved necessity. The government has the responsibility for developing and co-ordinating an over-all plan of hospitalization for all residents in Manitoba. The hospital, in its turn, is responsible for construction and operation of the hospital within the framework of the plan. As long as each party to the problem concentrates on meeting its own responsibilities the major problem of providing total hospital care will be solved.

*(For resolutions adopted and other notes see the January issue).* ■

# Yuletide Greetings

*Once again the Yuletide Season gives us an opportunity to wish our many friends a Very Merry Christmas and a Happy and Successful New Year.*

ESTABLISHED 1830

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# methods improvement in the hospital kitchen

**Margaret Ketchen, R.P.Dt.**
**Toronto, Ont.**

THE kitchen is a production centre, a very important production centre, spending about 25 per cent of the total hospital budget. Many routines used in modern manufacturing procedures may be applied to kitchen organization. Think what a difference this application of modern production methods should make to our work!

Automation, as applied to food production includes the use of conveyors, dispensers, portion control equipment, food processing machines, such as meat saw, choppers, grinders, et cetera. I would like to outline how these may be integrated into your present departments or planned for in a new kitchen in hospitals of various sizes.

Conveyors used for the assembly of trays, ready to be carried to the patient, or for the return of soiled dishes, are in wide use at present. They reduce hours of labour and allow greater flexibility of service. Supervision is easier and it is possible to have trained personnel check each item of food as it is served. Handling in store rooms is reduced by the use of fork-lift trucks, platform trucks and portable shelving or storage trucks in refrigerators.

Dispensers for dishes should be considered as a sound investment. Labour saved by using this method of storing dishes more than compensates for the additional expense, and dishes are always available as they are needed in any location. The units may be plugged in to warm the dishes. Many kinds of dispensers are in use—one for each type of dish. Plates of all sizes, fruit, cereal, et cetera are stored in stacks or piles. Racks in these dispensers take care of soup cups, creamers, tea pots, thermos jugs and all types of glasses. Combination dispensers accommodate racks of cups and stacks of saucers. We are also using this type of unit for storage of sliced bread on conveyor lines and cafeteria counters. Portable dispensers seem to be much more useful than those built into serving units.

The use of portable equipment leads to a very flexible service and ease of cleaning. There are very few units now in a modern kitchen which must remain fixed. Portable work tables, tables for toasters, milk dispensers, tart machines, food cutters, et cetera should be considered. Portable shelving for storerooms, refrigerators, and pot racks (both for clean and soiled utensils) are only a few of the units which save thousands of steps for workers. It is possible to provide food and supplies in the exact location where they are needed. Dollies for garbage tins and dish racks are also of great assistance.

Portion control equipment is important as well, and I would like to mention two examples which are very valuable. One is a meat-pattie machine, suitable for a large institution. The other is a unit for self-service coffee; the amount dispensed is carefully regulated.

Machinery for processing food includes all types of choppers, grinders and cutters as well as pie rollers, bun dividers, moulders and tart machines. Thermostatic controls and timers are now available on steamers similar to those on ranges, ovens and broilers. Automatic devices measuring liquids into stock pots are coming into wider use.

Providing modern equipment should justify for itself in reduced hours of labour. But it does not always follow that fewer workers are employed when labour saving equipment is added. However, this is an administrative problem and should not make us lose sight of the fact that the equipment, I have outlined, will be of inestimable value in reducing payrolls and producing better food, if it is properly used.

Centralization of preparation and service reduces the amount of equipment and the amount of labour. This automatically reduces the supervision necessary for efficient operation. Any new procedures are easier to institute and maintain when only one group of employees are asked to carry out detailed instructions. It may not be possible to centralize all preparation—but most operations will benefit if carried on in one location rather than in several. For instance, even if potatoes must be cooked in several locations, the peeling should be centralized. This results in less garbage transportation, less cleaning in the work area, as well as fewer peelers and reduced hours of work.

Centralized service is being widely used in hospital food services. Specially designed trucks as well as the conveyors already mentioned are used to transport trays after they have been served in a central location. This type of service eliminates costly equipment on the floors for food service and dishwashing, and provides more efficient methods for both these operations. It is also possible to reduce and control left-over food.

Standardization is another administrative principle which helps to reduce costs of labour and equipment. Trucks of the same type used in many locations and for many purposes eliminate the need for

*The author is director of nutrition, Toronto General Hospital, Toronto, Ont. From an address presented at the Saskatchewan Hospital Association annual meeting in October of this year.*

**Food Service**

**sponsored by the**

**Canadian Dietetic Association**

specially designed units. Standardized pans for serving make portion control easier. Standardized recipes with definite directions for serving are also valuable in improving quality of food, as well as reducing labour. You will realize how centralization and standardization work together, each rendering the other of more use.

Proper construction in the kitchen helps to keep cleaning to a minimum. Rounded corners, cove bases, and flush refrigerator floors all make floor washing less arduous. Portable equipment removes much of the drudgery of this operation. Tiled walls are easier to clean than painted. The absence of partitions removes one cleaning difficulty. Wide aisles, non-skid floors and reduced cross traffic are safety precautions which help to make our kitchens a safer and healthier place in which to work.

Dishwashing is one area where large amounts of money spent on research will point up the importance of efficient operation. Proper methods of handling, adequate temperatures, the correct detergent (best suited to the institution and the degree of hardness in the water) and the use of a wetting agent all contribute to reduced hours of work, clean dishes, silver and glassware.

Our department is now engaged in a project to find an easier method of cleaning and keeping clean stainless steel equipment. We are hoping to reduce the hours of labour used in this operation.

I would like to discuss briefly the use of prepared foods—cake mixes, preportioned meats, and peeled potatoes. Our experience has been that for a large institution it is more economical to have a butcher than to use prepared meat cuts. The latter practice involves purchasing of bones for soup and fat for frying. We also feel that it is possible to get meat of a higher quality when purchased by the carcass. But in a small hospital, use of preportioned meats reduces the bill for labour, and makes it easier to control the amounts of meat used. The omission of a butcher shop saves equipment and space.

Other prepared foods may or may not be of value to your operation—but each should be investigated on its own merits. Frozen foods are a valuable addition to hospital menus.

**Streamlining**

Administration of the dietary department also calls for streamlining of all procedures. One of the most dramatic changes has been the simplification of all types of special diets. We have found that this has resulted in increased satisfaction to patients and the decreased necessity for so much detailed supervision. Use of another tool of standardization, master menus, has made this part of our task easier in many ways. Detailed food costing throws a different light on food production and service, and offers still another challenge.

The acute shortage of help—both professional and unskilled — has pointed up the need for more training at all levels. One result of this shortage is the use of supervisors who are able to do routine work, to allow dietitians time to administer their departments more effectively.

Communications, a management tool, covers a wide range. All messages must be received, understood and interpreted correctly. They must be transmitted in language which is readily understood. Communications are also a function and a responsibility. They may also be a way of looking at the world, our jobs and ourselves.

In conclusion, I would like to summarize the aims for a methods improvement program.

1. Reducing hours of labour—(i) food preparation; (ii) cleaning; (iii) maintenance.
2. Reducing handling — (i) supplies; (ii) equipment.
3. Using new procedures—(i) food stuffs; (ii) equipment.
4. Increasing safety precautions.
5. Providing better working conditions for employees.
6. Most important — providing better patient care. This means for our department, better food. ■

## A.C.H.A. Activities

**Award Winners Selected**

Winners of three of the College's top awards, the James A. Hamilton Hospital Administrators' Award, the Article Awards and the Edgar C. Hayhow Award were announced recently.

Melville Dalton, a faculty member of the University of California, was granted the first of these for his book, *Men Who Manage*. This book, published by John Wiley & Sons of New York, was selected by the College's Book Award Committee for the Congress on Administration, as an outstanding work in the field of administration.

The winner of the Article Award, granted for an outstanding article on administration, was Ray E. Brown, immediate past-president of the College and superintendent of the University of Chicago Clinics and chairman of the Nation-General Planning Committee for the Congress. Mr. Brown won the coveted prize for his article, "The Nature of Administration", one of a series published in *The Modern Hospital*, November, 1959.

The third award was given to Warren G. Bennis, associate professor, School of Industrial Management, Massachusetts Institute of Technology, for his article, "Problem-oriented Administration", published in the winter issue of *Hospital Administration*.

All three award winners will be honoured at a special Awards Luncheon, a new event, to be held on February 3, during the Congress on Administration, in Chicago.

**Seminar Speakers**

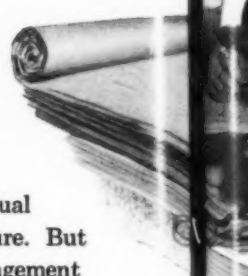
A "live" key speaker for each of the 20 management seminars to be presented during the forthcoming fourth annual congress is planned by the Seminar Materials Development Committee.

Invitations have been extended to the authors of articles being used as springboards to discussion at each of the seminars. In addition to the key speaker, who will be asked to present a 20-minute summation of his particular administrative research, the seminars will feature a panel of hospital administrators who will guide the discussions.

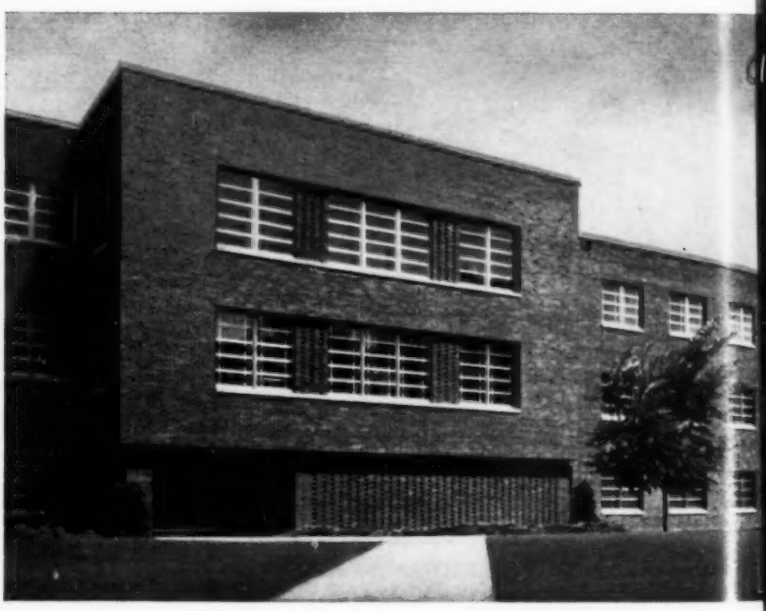
Among the men who have already accepted the invitation are: Walter L. Daykin, professor of labour and management, University of Iowa, Louis W. Norris, president, Albion College, Mich., Kenneth E. Richards, personnel research manager, United Airlines Inc., and Harold E. Sponberg, president, Northern Michigan College. ■

# How *Imaginative Engineering* Uses Pneumatic Temperature Control To Guarantee Year 'Round Patient Comfort

Scott & Kinney, Kansas City consulting engineers, took a new look at an old problem and designed a *different* heating and air conditioning system for the University of Kansas Psychiatry Building. Their unusual method features two separate fan systems and a unique automatic damper application that eliminates the noise and distribution problems usually encountered with ordinary single-fan systems.



Providing uniform year 'round temperature together with foolproof individual room control has always been a problem in designing buildings of this nature. But Scott & Kinney provided the solution in their selection and imaginative arrangement of a Powers Pneumatic Control System.

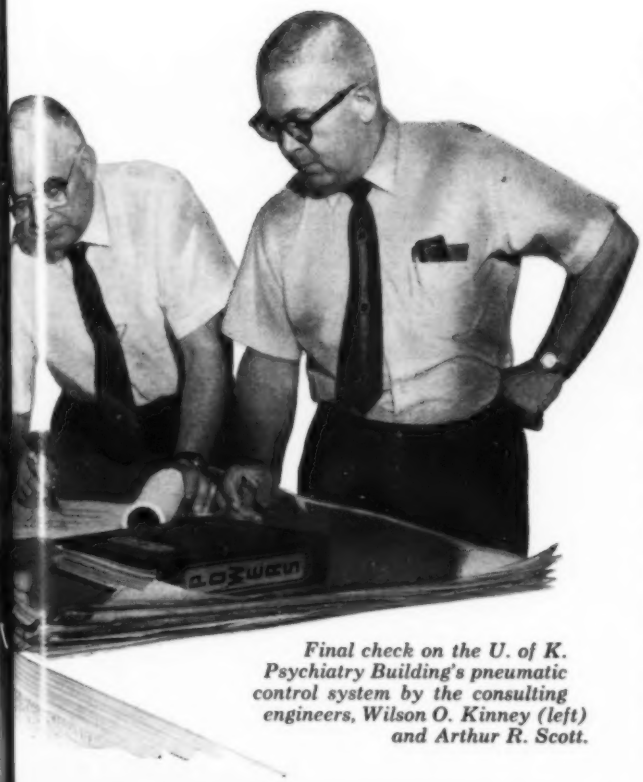


*Building "G", University of Kansas Medical Center*

**ARCHITECTS:**
*Kansas State Architectural Dept., Topeka, Kansas*

**CONSULTING ENGINEERS:**
*Scott & Kinney, Kansas City, Missouri*

**MECHANICAL CONTRACTOR:**
*A. D. Jacobson Plumbing & Heating, Inc., Kansas City, Missouri*



*Final check on the U. of K. Psychiatry Building's pneumatic control system by the consulting engineers, Wilson O. Kinney (left) and Arthur R. Scott.*

Heating, ventilating and air conditioning are accomplished through primary and secondary air systems. The primary system operates throughout the year, supplying a small amount of circulated air, including outside air. Final control in the primary system is a reheat coil — one for each patient room — using hot water with a Powers modulating packless valve.

Heart of the secondary — or booster — system is the automatic, quick-acting diverting damper. It permits both fresh and refrigerated air to pass into the individual rooms through a ceiling diffuser. When cooled air is not needed, it is diverted automatically by the damper into the ceiling plenum for return to the secondary fan.

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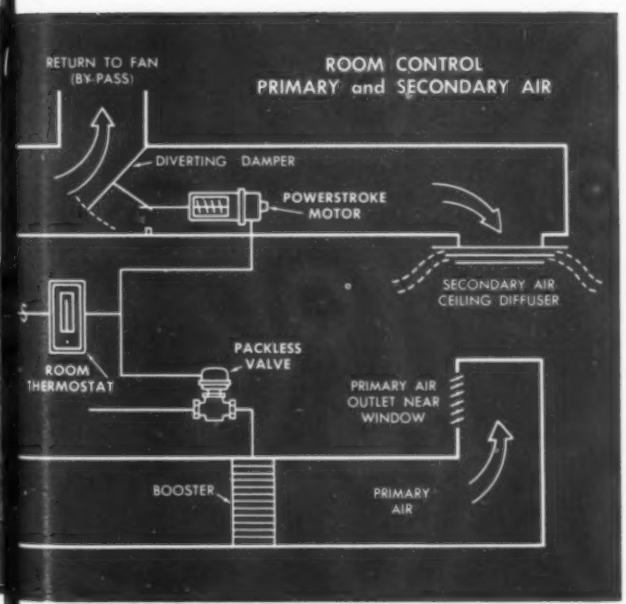
This imaginative handling of standard Powers temperature control equipment is another example of problem-solving by the consulting engineer and the specialized help of Powers field engineers. The University of Kansas has reaped the benefits for the last four years — in comfort, operating economy and low cost maintenance.

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# With the Auxiliaries

## GOLDEN JUBILEE

**Mrs. W. A. Campbell,**
**Kingston, Ont.**

TO DO JUSTICE to the story of the Golden Anniversary of the Women's Hospital Auxiliaries Association of Ontario, and yet stay within the allotted space, is a difficult task.

Imagine if you can, a throng of delegates, representing 170 hospital auxiliaries, meeting together in the Royal York Hotel, Toronto, to celebrate and be part of a gigantic birthday party, then you will have some idea of the magnitude of the affair. This meeting was held in conjunction with the Ontario Hospital Association convention, October 24 to 26.

There are 69,941 hospital auxiliary members in Ontario and though all could not attend, they saw to it that they were well represented. There were 504 registrations. Chairs at meetings and at discussions were at a premium, and there were no dull moments. Speakers at the meetings and at the banquet were filled with enthusiasm for their work and possessed of the ability to kindle similar enthusiasm in the minds of their listeners.

Mrs. W. P. Telford, the newly elected president of the W.H.A.A., impressed everyone by her poise, wisdom and sincerity. Not content to see auxiliaries continue operating along the same old lines, she advocated increased volunteer services, suggested that members plan well for the future and, especially, that they recognize and make use of the great potential that is to be found among young people. "By forming junior auxiliaries now, we may assure ourselves of volunteers and able directors to fill the gaps in the years ahead," she said.

Everywhere delegates learned of the importance of public relations in hospital work. It was impressed on them that a good member must be an informed member, for the interpretation of the hospital story to the community is of great importance. Auxiliary public relations are a part of hospital public relations so that anything done or said to promote public interest and good will is bound to benefit all concerned. The raising of money ($899,159.09 was raised in Ontario last year) should not take precedence over the fostering of good will in the community. Bulletins and news letters should be used more extensively to keep people aware of what is going on. Mrs. J. Beaudoin Handfield, public relations administrator for the National Council of Hospital Auxiliaries, one of the guest speakers, also stressed the value of good publicity, and the value and importance of the volunteer in hospital work.

*Looking over the program are l. to r. Rt. Rev. John G. Fullerton, D.P., vice-chairman Ontario Hospital Services Commission; Mrs. W. P. Telford, president of the W.H.A.A.; Mrs. J. D. Good, London, honorary life member; and Philip Rhynas, son of Mrs. O. W. Rhynas, president of the provincial association for 17 years.*

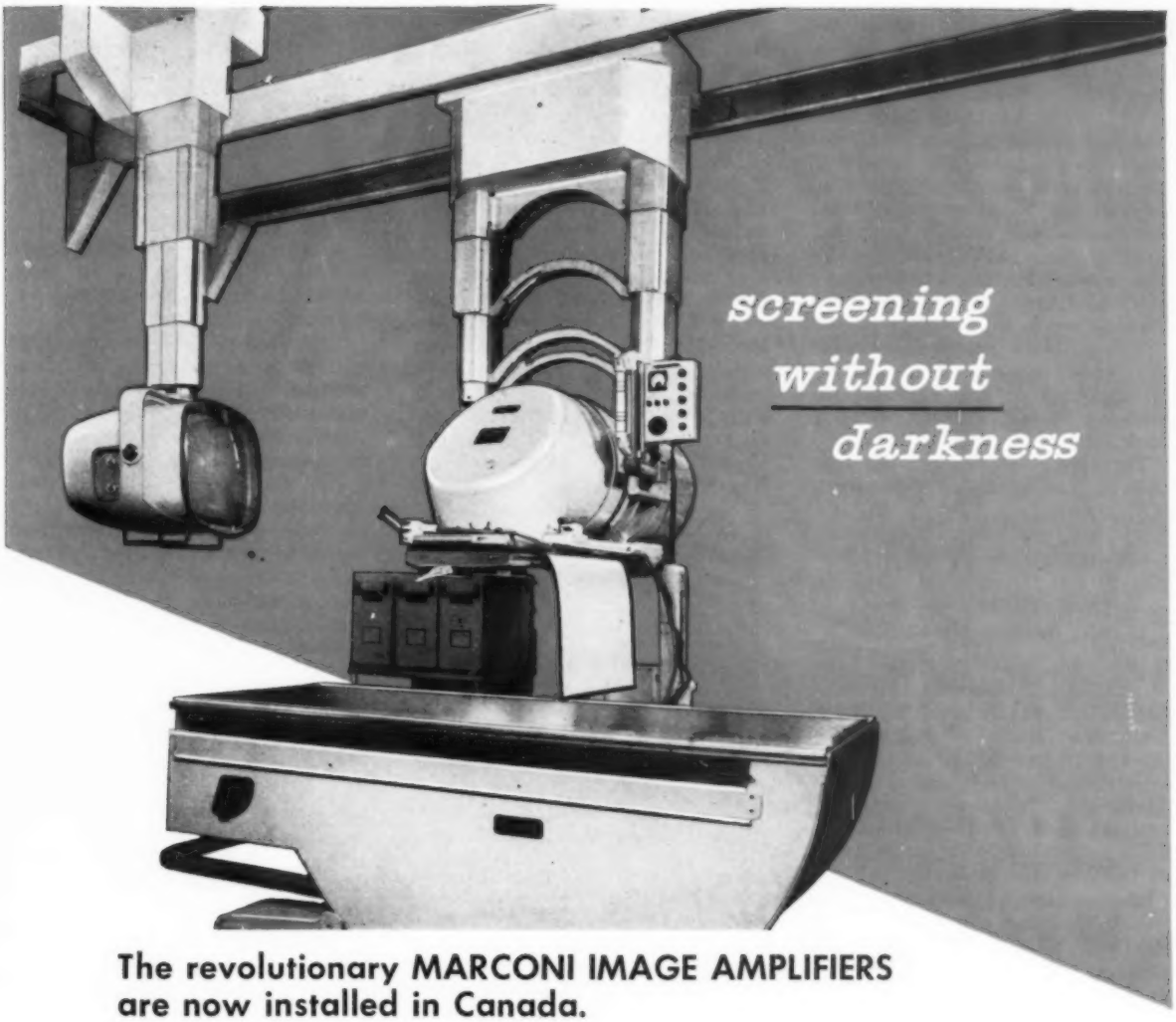
Those who spoke during the "project parade" gave each person present something to think about. Here, tales of services rendered to hospital and community, tales of great accomplishments stemming from small beginnings, and tales of comfort brought to the aged and to the hopelessly ill, were told in detail. No one listening to these women could help but be inspired to go and do likewise.

Round table discussions popped up like mushrooms all over the place, the audience participation turned them into lively affairs. Everyone seemed happy to allow others to pick their brains in search of new ideas, and many told of their mistakes and failures that the rest might profit by them and avoid similar pitfalls. Here, too, auxiliary members received tips on coffee shop and gift shop management, wagon services and other activities dear to their hearts. All kinds of useful ideas were presented. At these discussions, the voices of great metropolitan hospitals and also of small rural ones were heard. Eleven new auxiliaries, who joined the Association last year, were represented, as well as auxiliary members from hospitals which do not exist except on the architect's drawing board. These women are preparing themselves and will be ready to go, the minute the doors are opened. More power to them!

The public relations exhibit was worth several visits. Here, photographs of various and varied volunteer activities were displayed, as well as samples of gift shop merchandise, tray trimmings and other eye catchers. No one left that room without some fresh idea in her head to pass on to the home group.

The highlight of the convention was the Golden Jubilee Banquet, and from the candles on the tables to the ashtray and matchbook souvenirs, it was indeed a golden occasion. Greetings were brought by Health Minister M. B. Dymond, honorary president, Mrs. J. Cecil McDougall, national president, and Mrs. Palmer Gaillard Jr. of Mobile, Alabama, who is past chairman of the American Council of Hospital Auxiliaries.

Mrs. C. W. Sheridan, first vice-president of the provincial association, conducted the candle-lighting ceremony. The ceremony was symbolic and impressive. Lights in the hall were turned off, and from a single, lighted taper, passed from

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hand to hand, one by one, all the candles on the tables were lighted and sent up their bright flames to dispel the darkness.

Mrs. W. C. Vaughan, the immediate past-president, entertained delegates as she traced the history of the provincial association from 1910 to 1960, and her story proved what the candles had already told, that one tiny spark in the heart of someone, somewhere, can kindle others until eventually, one by one, each dark corner is lighted.

The birthday party closed with the presentation of honorary life memberships in the W.H.A.A. to honour a few chosen ones for their work in hospital and community.

The officers elected for the year 1960-61 are as follows: *honorary president*, Hon. M. B. Dymond, M.D., Minister of Health for Ontario; *honorary vice-president*, Mrs. J. A. Aylen, president of the Ontario Hospital Association; *immediate past president*, Mrs. W. C. Vaughan, St. Catharines; *president*, Mrs. W. P. Telford, Owen Sound; *president-elect*, Mrs. C. W. Sheridan, Ottawa; *second vice-president*, Mrs. Wm. Smolkin, Perth; *third vice-president*, Mrs. C. G. Fraser, Hamilton; *fourth vice-president*, Mary Percival, Sudbury; *recording secretary*, Mrs. H. H. Japp, Chatham; *corresponding secretary*, Mrs. K. Bowes, Owen Sound; *treasurer*, Mrs. H. B. Knap, Toronto; *public relations director*, Mrs. J. C. MacMicking, Markham; and *secretary of regions*, Mrs. E. E. Stanfield, Tillsonburg. ■

## Manitoba Meeting

**Mrs. Gordon Davis,**
**Belmont, Man.**

THE 14th annual meeting of the Manitoba Women's Hospital Association was held in the Royal Alexandra Hotel, Winnipeg, on October 19 and 20, in conjunction with the Hospital and Nursing Conference. It was exceptionally well attended by a group of enthusiastic, friendly delegates from all parts of the province.

The meeting opened with the president's report given by Christina MacLeod. She reported that the mailing list now stands at 96, including a new auxiliary group which was formed during the past year.

In order to arouse the interest of students in nursing careers, all high school principals at the meeting were given kits providing information on nursing courses. The kits were to be distributed to students.

The president's report was followed by the treasurer's report and the reports of the regional representatives.

In the afternoon around 125 delegates went on a tour of St. Boniface Hospital. There, the operation of an artificial heart was explained by a physician and they were permitted to watch the removal of a tumor. The tour was of great interest to everyone.

The following morning was devoted to group discussions. Members split into groups according to the size of the hospital they represented. Projects and problems were discussed and findings presented. Members expressed a desire to have something similar to this repeated again next year.

*Mrs. A. S. Williams, public relations chairman and Miss Christina MacLeod, immediate past-president, both of the Women's Hospital Auxiliaries Association, inspecting one of the many exhibits.*

It was noted that during the past year the first life member had died, and two new life members had been received.

The guest speaker at the luncheon was Leslie Truelove, M.D., chief of staff of the Manitoba Rehabilitation Centre, which is being constructed to serve the whole of Manitoba. A fashion show followed the luncheon.

The officers for the year 1960-61 are as follows: *president*, Mrs. W. D. Aime, Clandeboye; *recording secretary*, Mrs. M. T. Ormiston, Winnipeg; *corresponding secretary*, Mrs. H. C. Hutchison, Winnipeg; *treasurer*, Mrs. Hugh Lippmann, Winnipeg; *public relations officers*, Mrs. Gordon Davis, Belmont and Mrs. T. A. J. Cunnings, Winnipeg. ■

*The author is public relations chairman of the Manitoba Women's Hospital Association.*

## *Book Review*

GREAT ADVENTURES IN NURSING, Edited by Helen Wright and Samuel Rapport. Published by Harper & Brothers, New York, May 1960. Pp. 288. Price $3.50.

This collection of short stories is one more addition to the already extensive field of literature portraying the drama, heroism and sacrifice of the nursing profession.

The book is divided into four main sections; the "Prologue", "Hospital Adventures", "From the Jungle to the Slum", and "Adventures in War". The prologue includes the Florence Nightingale pledge taken by all nurses at the time of their graduation. The following three sections include selections from works written by or about nurses, illustrating an incident or experience in their careers. Some stories are excerpts from biographies of famous nurses such as the inevitable Florence Nightingale.

In the section "Hospital Adventures" stories have been selected to illustrate why young women enter the nursing profession and why despite hard work and demanding requirements no other career will suit them.

Some of the authors describing their experiences are Sister Elizabeth Kenny, who tells how she first treated polio victims in the Australian bush; Princess Ileana of Romania relates her adventures as a nurse in war-time Romania. John Farrow describes the work of Father Damien and his life with the lepers. Other selections deal with the experiences of Lilian Wald, Mother Bickerdyke and Florence Nightingale.

Most of the stories are written in the first person in a very simple narrative style. Although they are by various authors, the general pattern of each selection seems to be the same throughout the book. Secrifice, selflessness, drama and heroism runs through most of the stories with a touch of humour here and there. The collection of stories seems to exalt only one side of the nursing profession neglecting to offer any glimpse of the other side —the day-to-day routine, the mistakes and failures, the difficulties encountered when dealing with some patients.

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*—English Digest*

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# 7 ways to improve patient care and hospital efficiency

**...through the functional use of communications and sound**

Well-planned Executone sound-communication systems can perform heroic labors in the hospital. More than 30 different applications have been designed. Seven broad areas are detailed here. They are capable of lifting many burdens that high costs and personnel shortages impose on patients, administrators and staff.

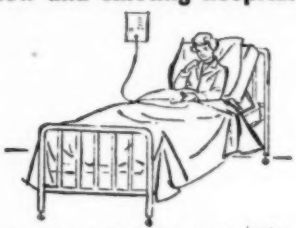
## 1. Provide for instant command-response in surgery

Lives can be saved by immediate response to doctors' commands in the Surgical Suite. It is vital that a surgeon obtain assistance from remote departments with as much dispatch as he receives an instrument from his Operating Nurse. He may, for instance, have to suspend an operation until a report on a specimen can be obtained from Pathology ... until Blood Bank or Sterile Surgical Supply can fill an unforeseen need.

Executone's intercom systems put these services at the surgeon's immediate disposal. They fulfill special requirements of the Operating Room—explosion-proofing ... foot-operation ... extremely well-modulated voice reproduction. They can, in addition, be used to transmit 2-way voice communication between the surgeon and students.

In other than surgical areas where urgent situations arise, action can almost always be expedited by properly-specified Executone communications.

## 2. Raise nurses' productivity; improve bed-patient care ...in new and existing hospitals



Time and motion studies have proved that nurses' foot travel can be reduced by as much as 65%. At the same time, more duties can be assumed by orderlies, aides and Practical Nurses. The source of these skilled-labor-savings is the Executone audio-visual nurse call system. It can make a reduced nursing staff more responsive to the patients' needs.

In most cases, it can be installed using existing nurse call wiring. An effective audio-visual system will incorporate the following factors:

a. ability of patients, including those unable to move or speak normally, to use the system effortlessly.

b. operation of the system with all its advantages regardless of the location of nurses at any given moment, or the number of calls registered.

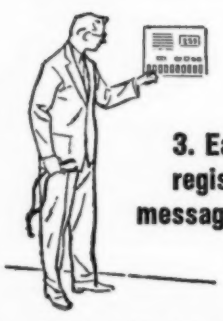
c. provisions to avoid a patient's being unable to signal.

d. psychological reassurances—of the proper registration of a patient's call, and the maintenance of his privacy.

e. foolproof, urgent-priority call registration from bathroom stations.

f. use of the system to monitor sounds in post-operative cases, polio or seclusion wards, nurseries, etc.

A demonstration of Executone's advanced nurse call equipment will show you how all these functions and safeguards can be implemented, and a system designed for any set of requirements.



## 3. Ease doctors' registration and message problems

In-out registration and message collection duties are so burdensome to doctors that many frequently neglect these essentials. Confusion and delays result. Executone, however, makes available a variety of systems designed to relieve this condition. One notable advance is Executone's simplified, one-stop register-and-message facility.

This facility is made available to the doctor at all habitually used entrances. Each register is tied in to a central compact "memory" unit at the hospital message center. The doctor need only punch

his own 3-number code into the nearest register and indicate whether he is entering or leaving. This information is stored in the "memory" unit and is instantly available at *any* register. If there are messages for a doctor when he uses a register, a blinking light alerts him, and he may speak to the message center by 2-way intercom. The use of a central "memory" unit makes possible significant economies in wiring.

## 4. Increase the versatility of doctor-paging systems

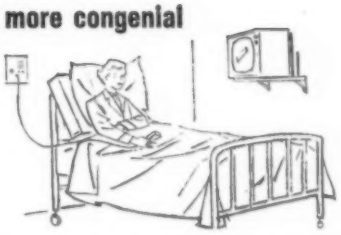
The paging facilities in today's hospital can offer a far greater range of service—thanks to Executone's multi-purpose systems. Not only does this equipment make possible a variety of interchangeable paging methods, but it will accommodate background music and alarm functions as well.

In addition to the conventional all-hospital page, the Executone-equipped paging center may use:

**zoned paging.** A sequence of zoned pages will usually locate a doctor without disturbing the entire hospital. A typical sequence might be: obstetrical suite . . . maternity ward . . . doctors' lounges and dining rooms.

**localized paging.** This system operates as above—with this exception: On floors or wards served by nurses' stations, paging is restricted to the duty area. The nurse completes the page by selective use of the nurse call system. This method gives maximum quiet in patient areas.

## 5. Make the hospital environment more congenial



Sound can be genuinely therapeutic. Leading administrators attach great importance to its use for diversion and entertainment. They favor the availability of music—in wards and labor rooms, for example, as well as waiting rooms and visitors' facilities. Chapel services can be transmitted to the rooms of patients who so desire.

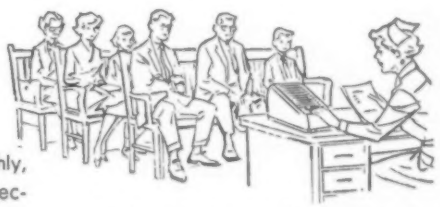
Executone's versatile paging and nurse call systems readily handle these additional functions. For example, each patient can be supplied with an Executone Pillow Speaker and controls. This remarkably compact instrument is a high quality sound reproducer . . . radio station and TV channel selector . . . volume control . . . and nurse call cord set—all in one. No radios are needed in the rooms. Programs—and records or tapes—originate at a central control rack.

## 6. Speed internal action; keep telephone lines free

Reliance on the telephone for internal communication in the hospital often results in delay and switchboard congestion. Efficiency requires a channel of communication independent of the telephone . . . in order that administrators may have direct contact with heads of departments . . . that related departments be in instant touch with one another . . . that there be adequate intercom facilities within departments.

Executone's intercom systems have proved their worth in hundreds of hospitals – in terms of increased staff productivity, time savings, and freeing switchboards for rapid response to emergency calls.

## 7. Expedite out-patient, clinic and emergency service



Traffic can be made to flow smoothly, and doctors' time conserved, by effective communications in departments serving ambulatory patients. Emergency admissions, too, can be handled with efficiency . . . day and night.

Executone intercommunication – between nurses' stations and the medical facilities they serve – is the key to improved operation in these areas. An ambulance entrance which is not regularly staffed at night can be made functional around the clock—by the use of an outdoor Executone ambulance intercom station to summon proper personnel upon arrival of an emergency case.

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**O.H.A.**
*(continued from page 41)*

Orthopaedic Hospital, spoke on the importance of budgeting for the housekeeper. Without a budget, a department cannot function efficiently. The hospital's cleanliness, the patients' morale and good public opinion are all dependent on the smooth functioning of the housekeeping department. Moreover, by planning future expenses in a systematic manner, the housekeeper can make substantial savings for the hospital. Mr. Brown enlarged on this by stating that 65 to 70 per cent of the money is spent on staff salaries; the balance goes towards supplies. Since salaries make up the largest single item, it is here that the savings can be made. This does not mean a reduction in staff salaries; rather, it calls for work simplification which brings about improved efficiency and a reduction in staff, which in turn can be translated into savings in dollars and cents.

Mr. Brown's informative address was followed by a panel discussion on organization and management. Bram Allington summed up the discussion by presenting some thoughts and suggestions on housekeepers' tools and how to use them. A housekeeper should draw up an outline of duties to give an overall picture; set up a detailed floor plan showing the areas to be cleaned; decide on a standard of cleanliness to determine the frequency and manner of operation; run a time study to find out the number of man hours required; have an approved work schedule; and establish a training program followed by careful supervision.

The officers for 1960 61 are as follows: *president*, S. Chobrzynski, personnel manager, St. Michael's Hospital, Toronto; *vice-president*, Mrs. W. Russell, housekeeper, The Workmen's Compensation Board Hospital and Rehabilitation Centre, Toronto; *secretary*, Alice Ball, housekeeper, Northwestern General Hospital, Toronto.

**Methods Improvement**

Charles B. Womer, assistant director, University Hospitals, Cleveland, Ohio, "looked" for an hour at methods improvement programs. He defined such a program as "the organized use of common sense to find easier and better ways of doing work". It involves developing in hospital personnel a positive attitude toward improvement and the effort must be a continuing one. A methods improvement program is a tool of management, he said, and it can be approached (1) in a "do it yourself" or decentralized fashion through line organization; or (2) in a centralized way. The latter centres responsibility for the program in a small group or in the use of outside consultants. The speaker discussed both systems, their pros and cons, at some length. He was of the opinion that a combination of the two systems is generally the best. Mr. Womer emphasized that, whatever type of program is used, it must be tailored to "the needs and personality of your organization and the persons who make up that organization". He also stressed simplicity and outlined a possible pattern which he thought could be applied to almost any situation. But whatever the pattern, said Mr. Womer, it is "most important to recognize that we are in a dynamic, ever-changing situation".

**Nursing Administration**

A panel discussion on "Developing Leadership Within Nursing Service Administration" was held, with Edith McDowell, M.A., University of Western Ontario, London, as moderator.

Brother B. R. Philip, F.S.C., head of the Department of Psychology, Assumption University of Windsor, dwelt on the qualities of leadership. He emphasized that the leader should have intelligence and integrity and a capacity to motivate staff and personnel. The leader should be acceptable to the group, he said, and should be prepared to bear burdens over and above those carried by the rank and file.

The speaker deplored leaders who are autocratic and make decisions without regard to the wishes of those in the lower echelons of the organization. Democratic leadership, on the other hand, creates motivation by encouraging all levels of staff to participate in planning and in implementing new ideas. The effective leader will not fail to meet new challenges and will take a positive approach in adjusting to modern concepts.

Every individual, he declared, has some qualities of leadership which can be developed in the right climate, and leaders of small

## CANADIAN SOCIETY OF LABORATORY TECHNOLOGISTS

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Canadian Hospital Association

February 20-24 inclusive

Welland County General Hospital,
Welland, Ontario

The Institute is being conducted by the C.S.L.T. Science Section of Immunohaematology, with the assistance of other highly qualified people, as an opportunity for technical personnel to improve their knowledge of blood bank procedures. It is intended principally for the minimally trained person in this field as an aid to solving work problems and not for those whose interest is to specialize. Registration will be limited to 30.

This program will be carried out in Ontario for members of the C.S.L.T., both registered and associate. Application forms will shortly be going out to members in this area. Applications from outside the area will be welcomed and anyone interested may obtain forms by writing to the C.S.L.T. executive office, 61 Victoria Avenue North, Hamilton, before January 10, 1961.

At a later date the C.S.L.T. hopes to be able to offer this and other programs in various areas.

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groups are as necessary as leaders of large corporations and nations.

Ellen C. McLean, director of nursing, Northwestern General Hospital, Toronto, discussed the effect of changing practices in nursing on the rôle of the professional nurse. Trends in nursing procedures, she said, are responsible for replacing "muscle with brainpower" by introducing complex machinery in the care of acutely ill patients. Nurses are taking over many duties which were previously the responsibility of the doctor. The nurse in turn is delegating simple procedures to members of the auxiliary staff.

The use of various categories of staff in providing patient care has brought into being the "team plan" which requires, for successful operation, leadership qualities on the part of the professional nurse. Although the nurse still gives direct care to the patient, she is also required to delegate, direct and supervise the work of the members of her team.

The headquarters of the nursing service department, *i.e.*, the nursing office, should have a responsibility to promote leadership qualities in nurses. This was the opinion expressed by Jean Dodds, nursing service supervisor, Toronto General Hospital.

She spoke on ways to motivate staff to assume the leadership rôle and suggested that a program of staff development should begin with the introduction of new staff members to the hospital and ward. She also indicated that the head nurse is the key person in the orientation of new personnel.

The director of nursing should be interested in promoting leadership among her supervisory staff and should establish a system of committees with representation from the various levels of nurses. In committees, policies and procedures relating to the nursing functions are reviewed and revised as necessary. The speaker added that work on committees provides an opportunity for the young nurse to learn to analyze, to explain and generally to gain experience as a group leader. Miss Dodds said that because of the emphasis given, in recent years, to the administrative function in nursing, post-basic education in nursing service administration is becoming a necessary requirement for nurses in supervisory positions.

Sister St. Louis, C.S.J., director of nursing, Sudbury General Hospital, discussed the need to create an appreciation of leadership qualities in the student nurse. This, she said, could be done through planned experience. Students with an aptitude for leadership should be given an opportunity to develop this potential early in their basic program of education.

Inspiration should come from the ward situation rather than from the classroom, with the supervisor of nursing service demonstrating the rôle of a leader. Experience as team leader, during the student's senior year, will provide an opportunity to evaluate her performance and to gage the degree of her administrative potential.

The inclusion in the curriculum of topics dealing with human relations, communicative skills, and with the professional person's responsibility to give leadership as a member of society, should be given serious consideration in attempting to motivate professional nurses to assume leadership responsibility, said Sister St. Louis.

**Officers and Directors**

The officers of the O.H.A. for 1960-61 are as follows: *honorary president*, Hon. M. B. Dymond M.D., Minister of Health for Ontario; *honorary vice-president*, Anthony F. Fuerth, Windsor; *president*, Mrs. J. A. Aylen, Ottawa:

*(concluded on page 72)*

## Coming Events

**1961**

**Feb. 2-4—American College of Hospital Administrators, Morrison Hotel, Chicago, Ill.**

**Feb. 6-8—Fourth Annual Refresher Course, School of Hygiene, University of Toronto.**

**Feb. 20-24—Institute on Immunohaematology sponsored by Canadian Society of Laboratory Technologists, Welland County General Hospital, Welland, Ont.**

**March 3—Canadian Nurses' Association—Canadian Hospital Association Joint Committee Meeting, Nursing Unit Administration, 25 Imperial Street, Toronto, Ont.**

**March 4—Canadian Hospital Association Committee on Education, 25 Imperial Street, Toronto, Ont.**

**Mar. 17—Meeting of the Executive Committee, Canadian Hospital Association, 25 Imperial Street, Toronto, Ont.**

**Mar. 18—Meeting of the Board of Directors, Canadian Hospital Association, 25 Imperial Street, Toronto, Ont.**

**March 22-24—American College of Hospital Administrators Regional Members Conference, Macdonald Hotel, Edmonton, Alta.**

**April 4-7—Maritime Hospital Association Institute on Administration, Moncton, N.B.**

**Apr. 19-21—Quebec Hospital Association, Montreal, Que.**

**May 1-5—American College of Hospital Administrators, Second Canadian Advanced Institute, Royal York Hotel, Toronto, Ont.**

**May 24-26—Canadian Hospital Association Assembly Meeting, Park Plaza Hotel, Toronto, Ont.**

**June 5-29—Hospital Organization and Management Summer Session, Toronto, Ont.**

**June 12-15—Catholic Hospital Association of United States and Canada, Detroit, Mich.**

**June 20-23—Western Canada Institute, Saskatoon, Sask.**

**June 26-28—Comité des Hôpitaux du Québec Convention, Montreal Show Mart Inc., Montreal, P.Q.**

**June . . . —Maritime Hospital Association, St. Andrews, N.B.**

**Sept. 10-14—International Tuberculosis Conference, Royal York Hotel, Toronto, Ont.**

**Sept. . . . —British Columbia Hospitals' Association Convention, Vancouver, B.C.**

**Sept. 25-28—American Hospital Association, Atlantic City, N.J.**

**Oct. 3-5—Manitoba Hospital and Nursing Conference, Royal Alexandra Hotel, Winnipeg, Man.**

**Oct. 10-12—Associated Hospitals of Alberta Convention, Calgary, Alta.**

**Oct. 23-25—Ontario Hospital Association, Royal York Hotel, Toronto, Ont.**

**P.S. Watch this column for announcements of C.H.A. institutes.**

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ment by the board of trustees if the medical staff is self-governing? What is meant by self-government of the medical staff?

Does it mean that when the board has supplied the facilities and people necessary to work for and with the physicians, the board's government ends there, and the medical staff takes over? It does not. For how then could the board assume their moral and legal responsibility for conduct of the hospital?

Does it mean that there are two authorities in the hospital, the board and the staff? It does not. For whence then would the administrator derive his authority? "No man can serve two masters." He would be compelled to "cling to the one and despise the other." He would certainly cling to the one which is properly discharging its responsibilities and despise the one which is neglecting them or is attempting to assume prerogatives it does not have either in law or social custom.

Does it mean that the medical staff in their delegated authority from the board is self-sufficient? It does not. For medical men of themselves have no power over one another. They are equal under the law. There is no governmental inequality among members of the medical profession. Their inequalities are clinical only. Any stratified classification of physicians is not inherent in the profession, but is of the institution or organization in which they serve. This is true wherever there is medical organization, whether it be in a hospital or in a government department, university medical school or medical clinic organization. It is when physicians accept the privilege of staff membership and are required to assume group responsibility that they must build an organizational structure. To assume this responsibility a classification of physicians and a hierarchy of membership is required.

The board has legal power and moral responsibility to provide patient care. The board delegates to the medical staff power to provide medical care for patients. It is to assume the responsibilities of this delegation that the physicians must organize themselves. Their hospital rank and titles are not of the profession but of the hospital organization. It is because members of the medical profession are treating patients *in the hospital* that they must develop a suitable organization to fulfill their hospital responsibilities.

The board is responsible for the conduct of the hospital and for everything that happens in it. The medical staff is responsible to the board. To fulfill their responsibilities to the board of trustees, the accreditation program says the medical staff must organize for two purposes: to insure high quality medical care for all patients at all times; and to assume responsibility for proper control of the professional conduct of all medical staff members.

Medical staff self-government, then, is not another state within a state. It does not represent another government within the hospital which may be rebel or dissident. It is not a group of people running a separate area of responsibility. Nor is it Her Majesty's loyal opposition sitting by constitutional sufferance, waiting their turn to take over power when the winds of public opinion change to make this possible.

Medical staff self-government has no power of its own. The only powers it has are delegated by the board. But always remember this: the medical staff has these delegated powers to do the one thing the board can't do, and that is give medical care to patients. The board can do everything else. It can supply the hospital and all the people and facilities necessary for the operation of the hospital, but it cannot give medical care. The whole organization lacks life until physicians accept the privilege of hospital medical staff membership and undertake the treatment of their patients in that institution.

You will notice that I said "their patients". The patients, as so forcibly pointed out by Dr. C. U. Letourneau in his new book on *Hospital Trusteeship*, are not the hospital's patients. They are the physician's patients. The patient does not cease to be the physician's patient when he is admitted to the hospital. Physicians will jealously guard the doctor-patient relationship. It is a relationship which exists by common consent and derives from centuries of tradition. It exists also in law.

Physicians derive their *hospital* privileges by delegated authority from the board, but they do not derive their right to practice medicine from the board. The hospital can neither practice medicine nor extend that right to others. The practice of medicine is permitted to physicians only. The provincial College of Physicians and Surgeons is the only body which can grant that right.

But if you have not any powers over the practice of medicine in the hospital, and if the physician-patient relationship is so sacrosanct, how can you assume the responsibility legally required of you to assure that high quality medical care is being provided? How can you do it? The answer is found in considerable detail in the documentation of the accreditation program. The best assurance of high quality care is that it is given by a medical staff properly organized for efficient self-government on the principles set by, and using the methods of procedure recommended by, the accreditation program.

If the hospital has any role in physician-patient relationships, surely it is to promote them by assuring both doctor and patient that means are supplied for good detection, diagnosis and treatment, of disease and injury. In our voluntary hospital system, the hospital can give good effect to the traditional doctor-patient relationship, and do it unobstrusively, by accepting the accreditation program's advocacy of medical staff self-government.

### Self-Government

What are some of the principles and recommended methods of procedure for this self-government? A credentials committee is required whereby the medical staff will assess the qualifications, experience, competence and worthiness of every medical staff member. When a staff member has been appointed, there is outlined a procedure for placing him in a category, *e.g.*, as active or otherwise, according to his potential activity in the hospital. It is required that, on appointment, he shall undertake not to engage in the division of professional fees and that he will agree to definite delineation of his clinical privileges; that he will agree to support hospital and medical staff policies; that he will keep good records of his professional work; and that the records of all professional work will be subject to review and analysis by the medical staff, as a whole, or in organized specified groups, on a monthly basis.

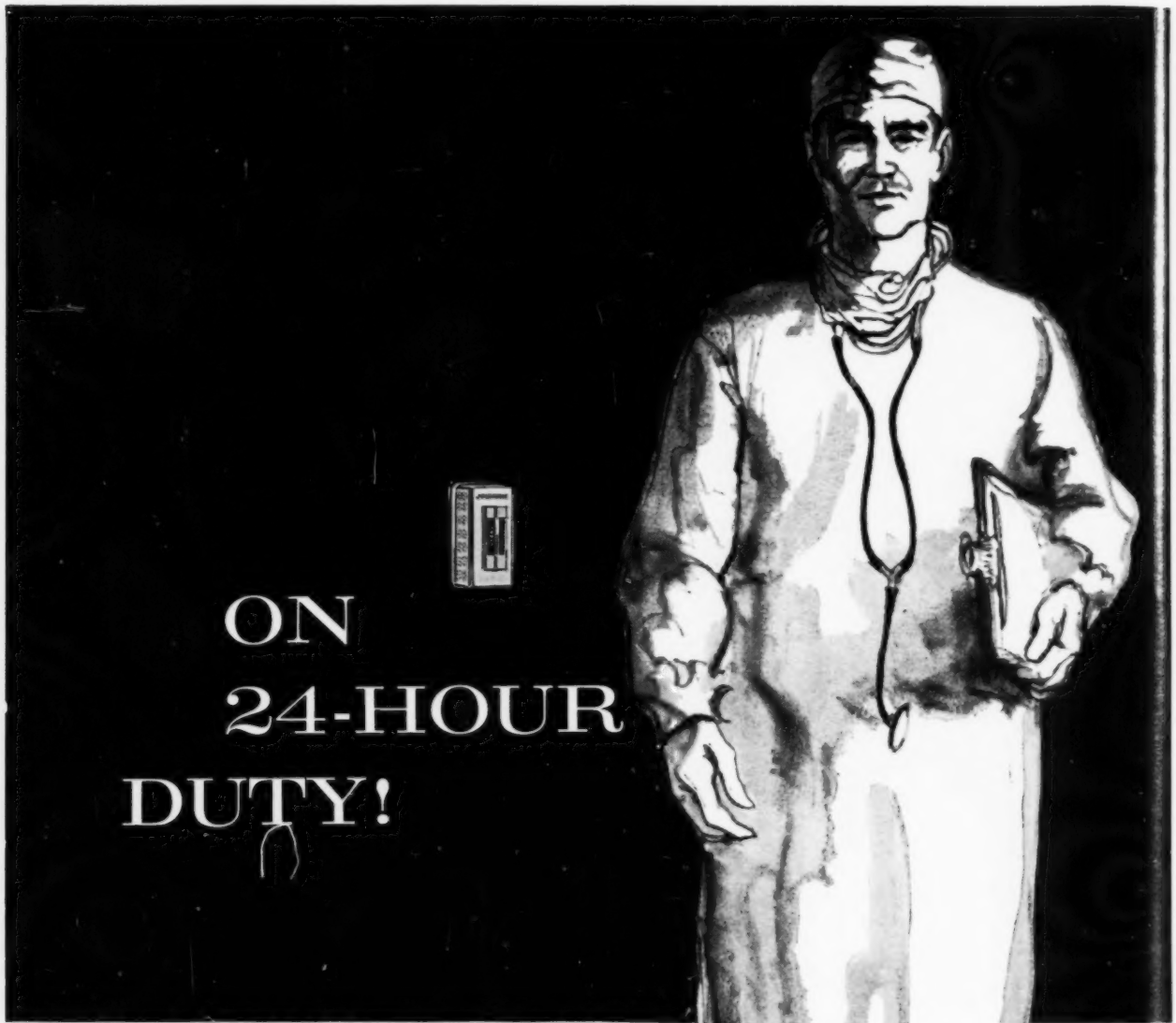
These are some of the ways in which you assure good quality medical care. There are others. The

program requires that there shall be proper officers of the medical staff, both elected and appointed; that there be a records committee to make sure that the records are always adequate to justify the diagnosis and warrant the treatment and end result; that there shall be a tissue committee which will carry on continuing education to abolish outmoded or discredited techniques and procedures, and strive for adoption of better methods of treating patients and of curing disease. The accreditation program says, also, that there should be a hospital infections committee which will investigate all hospital infections, try to trace their source, and assure their control; that there will be a pharmacy and therapeutics committee (essential for patient care but providing undoubted economic dividends); that there should be an admissions or bed occupancy committee (more often nowadays called a bed utilization committee), which will insure that patients are not admitted for reasons other than medical necessity, and that their treatment is prompt and appropriate; that there should be a disaster plan and a disaster committee of the hospital staff to make sure that, if there is any disaster within or outside the hospital, there will be adequate arrangements to look after it.

Very important, from the board's point of view, is the accreditation requirement for a joint conference committee. I need not here go into discussion of the constitution or terms of reference of a joint conference committee because these are fully described in the *Accreditation Guide*, but I do want to say that this is the only committee where you are likely to have close personal contact with the physicians and reasonably close contact with their patient-care problems. If you are wise, and if you are concerned about your responsibility for patient care, you will look to the function of a good joint conference committee.

The medical staff can never do their own job of providing good medical care in the hospital if the board and staff deal with each other at arm's length. Patient care is far too important to let either arrogance or ignorance rule hospital policies. Your responsibilities for medical care of patients are to a large extent your responsibilities to the medical staff, since all of their authority in the hospital is delegated authority from

*(concluded on page 68)*

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**Trustee Responsibility**
*(concluded from page 65)*

you. Without you they have none; none to sit in judgment of each other's work and each others privileges; none to be arrayed in hierarchial ranks; none to exercise professional discipline. Their legal license is to practise medicine. Your legal authority is to operate a hospital and in order that you may ensure proper order, discipline and control of patient care in the hospital, you must require physicians to assume tasks which, in a sense, are foreign to the direct doctor-patient relationship.

When we talk about government of any kind, we should remember that, whatever else government means, it means that authority is given to some people to exercise power over other people. The responsibilities of delegated power are great. Make sure your delegation of authority to the medical staff is commensurate with the responsibility you expect of them. Self-government of the medical staff will mean to you at least a method by which you can discharge your own responsibility for the medical care of patients. To the medical staff, self-government will mean at least protecting the freedom of the profession, a method by which they can properly assume group responsibility and at the same time guard and give effect to the sacred physician-patient relationship.

Medical staff self-government then is neither a means for physicians to avoid coming under hospital authority, nor is it a means for trustees to evade their responsibility for patient care. Medical staff self-government is the means by which a board of trustees may give to physicians powers they don't possess under law by virtue of their licensure, but which they need to fulfill their two major responsibilities in hospital—for the medical care of every patient and for the professional conduct of every staff member.

In summary, when you have provided the hospital and all things and people and all the organization and administration necessary, you still have not discharged your responsibility for medical care. You must see that patients in the hospital get good medical care. Physicians only can give that care, but physicians cannot do it in the hospital until they have hospital powers delegated from you to do it. The hospital powers of the physicians are delegated from the board of trustees. ■



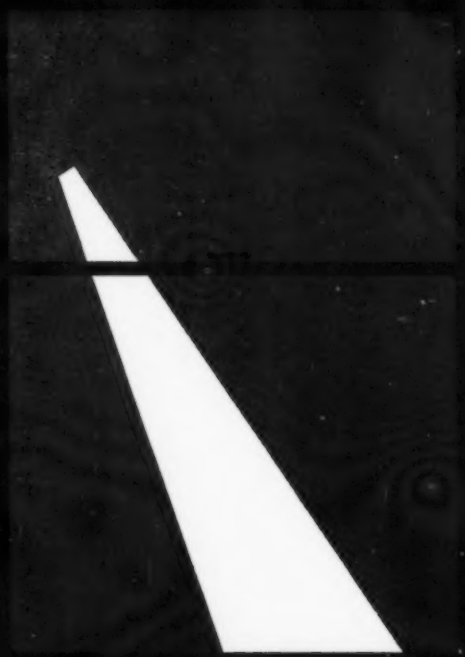
**Refresher Course at U. of T.**

The School of Hygiene at the University of Toronto is sponsoring the Fourth Annual Refresher Course to be held at the School of Hygiene from February 6 to 8, 1961. The whole program has been planned for physicians who are interested in preventive medicine, but the first day will be of special interest to hospital administrators and the third day to veterinarians.

The cost for the complete course is $35. Cheques should be sent to the Director, Division of Postgraduate Medical Foundation, Faculty of Medicine, University of Toronto, Toronto 5, Ontario.

**Change of Address for N.B.H.A.**

The New Brunswick Hospital Association announces change of address for its secretariat. The new address is: P.O. Box 1418, Fredericton, N.B. Executive secretary of the Association is C. G. Bird.



This is poor emergency lighting. It throws a beam in one direction — leaves 90% of the room in darkness.

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# THE STANDARD ELECTRIC TIME COMPANY OF CANADA LIMITED

Head Office and Plant: 103 GUN STREET, POINTE CLAIRE, P.Q.

HALIFAX MONTREAL TORONTO WINNIPEG CALGARY EDMONTON VANCOUVER

## Catholic Conference of Ontario

THE second day of the Ontario Conference of Catholic Hospitals held in October, was devoted to discussion of problems in modern nursing education. Rev. L. K. Shook, C.S.B., of St. Michael's College, University of Toronto, was the moderator of the panel.

Rev. J. E. MacGuigan, S.J., informed the audience of some 200 Sisters and a few lay teachers of what a school of nursing is expected to do for the young student who comes to nursing with high ideals and ambitions. Competency of the faculty will be reflected in the fulfilment of the objectives of the curriculum. The speaker stressed the importance of Catholic schools to take the lead in new programs.

Rev. Sister Denise Lefebvre, s.g.c., Ph.D., of Institute Marguerite D'Youville, Montreal, presented the picture of Canadian nursing and showed how the study and plans for Canadian Accreditation of Schools of Nursing is meant to upgrade nursing education standards, by clarifying the rôle of the school of nursing and its responsibility to nursing service in the preparation of the professional nurse.

The progress of nursing education from its beginnings was reviewed by Carol Adams, consultant and secretary of nursing education and nursing service, Registered Nurses' Association of Ontario. Miss Adams said that today the emphasis is essentially on preparation of the student as a person with many needs, which must be met by those responsible for her preparation, if she in turn is to take her place in the vast health plan of this province in the future.

Margaret Foley, M.S., of St. Louis, Mo., national secretary of Conference of Catholic Schools of Nursing, gave a clear and stimulating picture of the problems and progress in Catholic nursing education in the United States. She emphasized the wisdom of careful planning by well prepared persons, who will safeguard Catholic principles while meeting the modern challenge.

Rev. L. M. Danis, O.M.I., executive secretary of the Catholic Hospital Association of Canada gave a review of the activities of all provincial conferences and urged the Ontario Conference to continue its excellent work.

The incoming executive of the Conference is as follows: *president*, Sister M. Janet, C.S.J., Toronto; *first vice-president*, Sister M. Sheila, C.S.J., North Bay; *second vice-president*, Sister M. de Sales, C.S.J., Toronto; *third vice-president*, Sister Mooney, R.H.S.J., Kingston; and *secretary-treasurer*, Sister Jeanne Mance, R.H.S.J., St. Catharines. ■



### I.H.F. Moves to New Offices

On October 1st, 1960, the Secretariat of the International Hospital Federation moved to new offices at 24-26 London Bridge Street, London S.E.1. This move has been made possible by the generosity of the King Edward's Hospital Fund for London, which has for many years been a benefactor to the I.H.F. The I.H.F. will have a suite of four offices and a library/board-room at London Bridge Street, which will provide much-needed additional space.

**O.H.A.**
*(concluded from page 62)*

*president-elect*, M. B. Wallace, Toronto; *vice-presidents*, Sister M. Janet, Toronto, M. K. Humpage, Dunnville, B. G. Thacker, St. Thomas; *executive secretary-treasurer*, S. W. Martin, president of the Canadian Hospital Association.

The directors for next year are as follows: J. L. Bateman, Stratford; George F. Clark, Hamilton; R. Ray Copeland, Cooksville; R. C. Crandall, Tillsonburg; P. M. Dewan, Ingersoll; Proctor A. Dick, Chatham; H. T. Ewart, M.D., Hamilton; Rev. James Ferguson, Stratford; William A. Harris, Toronto; W. A. Holland, Oshawa; R. Alan Hay, Prescott; Lt.-Col. Hannah Janes, Toronto; R. R. Jessup, Sudbury; R. V. Johnston, Fort William; Mrs. D. E. Kerr-Lawson, Swastika; Carman J. Kirk, M.D., London; Carl J. Larsen, Walkerton; D. M. MacIntyre, Kingston; John MacKay, Peterborough; Arthur Marron, Q.C., Owen Sound; Mrs. Charles McLean, Toronto; Miss L. H. Parsons, Oakville; Glen W. Phelps, Orillia; E. C. Robinson, St. Catharines; O. B. Roger, Toronto; J. E. Sharpe, M.D., Toronto; Mrs. W. P. Telford, Owen Sound; Sister Teresa Agatha, Sault Ste. Marie; J. McIntosh Tutt, Brantford; C. N. Weber, Kitchener; E. R. Willcocks, Toronto.

*(For other sectional meetings and resolutions adopted by the Association see the January issue.)* ■

**Emergency Air Ambulance Service in Alberta**

The emergency air ambulance service organized by the Alberta Department of Health in 1959, fulfilled requests for assistance on 55 occasions during the first year of operation. The major portion of cost of the emergency flights was borne by the province. The average flight costs $287.75, but the patients are only charged a nominal fee of $25.

The average round trip of emergency calls was approximately 400 miles. Flights were made for such reasons as acute appendicitis, gun shot wounds, fractured skulls and pregnancy complications, and several others. A medical escort was required on 35 occasions.

Special equipment and medical supply kits are kept in readiness at the University of Alberta Hospital, Edmonton, while resident medical staff members may accompany a flight if necessary.

**Nursing Assistants**

There are 12 agencies in Ontario conducting approved training courses for nursing assistants, plus the Royal Canadian Army Medical Corps at Camp Borden for army nursing assistants. The Ontario Department of Health conducts courses in five centres in Ontario, including Toronto.

To date there are about 5,000 certified nursing assistants in Ontario. The course lasts 10 months and after the first eight weeks, an allowance of $60 a month is provided to assist with costs of room and board. Educational requirements are grade eight entrance certificate, or a letter from the principal of the school last attended. In October, 1957, the Department of Health offered an extension course at the Toronto centre in the form of a 12-month evening course.

Too many people are thinking of security instead of opportunity. They seem more afraid of life than death.—*James F. Byrnes.*

# HOLIDAY GREETINGS


G. BATTEN


G. MIDDLETON


P. HARDIE


C. McCAULEY




R. HARDIE


J. BURKE


D. HUTCHESON


J. FINAN


M. EDWARDS


R. PERRAULT


T. YOUNG


J. JONES


W. COCHRANE


W. SPENCER

**Gleanings from History**
*(concluded from page 33)*

Mance's Hôtel Dieu of Montreal, also based their constitution on the same Rule. Hospital personnel the world over would do well to read and to memorize the Rules and Constitutions of these orders. There you will find such sublime sentences as, "The spirit of our vocation is the love of God and of one's neighbour." Perhaps the reading of the Saint Augustinian concepts would do something to offset the materialism which has insinuated itself into hospitals, hospital administration, and hospital personnel. The stress placed on the mechanization, standardization, politicalization, and commercialization in hospitals during the past few decades offends one to the very core of his being. One finds it difficult to reconcile strikes and personal greed with the spirit of the Augustinian concept.

In reviewing the history of hospitalization in Canada, and especially in Quebec, one must also remember those two great monuments to public philanthropy and private enterprise — the Montreal General and the Royal Victoria Hospitals. Doctors trained in those hospitals have formed the nucleus of almost every medical teaching staff in Canada.

I have just used the term "private enterprise". In these times of governmental paternalism, with the state assuming so many responsibilities that were formerly considered *personal* responsibilities, it is almost heresy to speak in laudatory terms of private enterprise and individualism. In our Western civilization where we urge our young people to inflate themselves into economic and social chaos, "thrift" is almost a nasty word. It is not the intercontinental missile that I fear the most. It is the collective austerity program and the sixty-hour week of our potential enemies that I most fear. If I read history aright, civilizations rise with adversity and decline with prosperity. We as hospital personnel should carry the torch for the best possible patient service, but we must avoid extravagance. Otherwise we will spend ourselves into economic, social, and political slavery. We must realize that each time we delegate a personal responsibility to the state, we must relinquish a corresponding privilege. Even such a vital commodity as health can be bought at too high a price, if that price means the sacrifice of personal liberty.

To hospital personnel the world over, and to all people in all countries, may one recommend a study of the storied past. Without a knowledge of history there can be no intelligent appreciation of the contributions of the past; there can be no intelligent assessment of the present; and no intelligent planning for the future. Without a knowledge of the failures and successes of the past; without a knowledge of the contributions of each race and each civilization to the common weal of all society; we can not achieve our universal hope for universal brotherhood. Without a knowledge of history, there can not be a complete sense of our debt of gratitude to the past; and without gratitude man is an empty shell—a poor thing indeed.

May I conclude with the Augustinian quotation which I have already used?

"The spirit of our vocation is the love of God and of one's neighbour." ■

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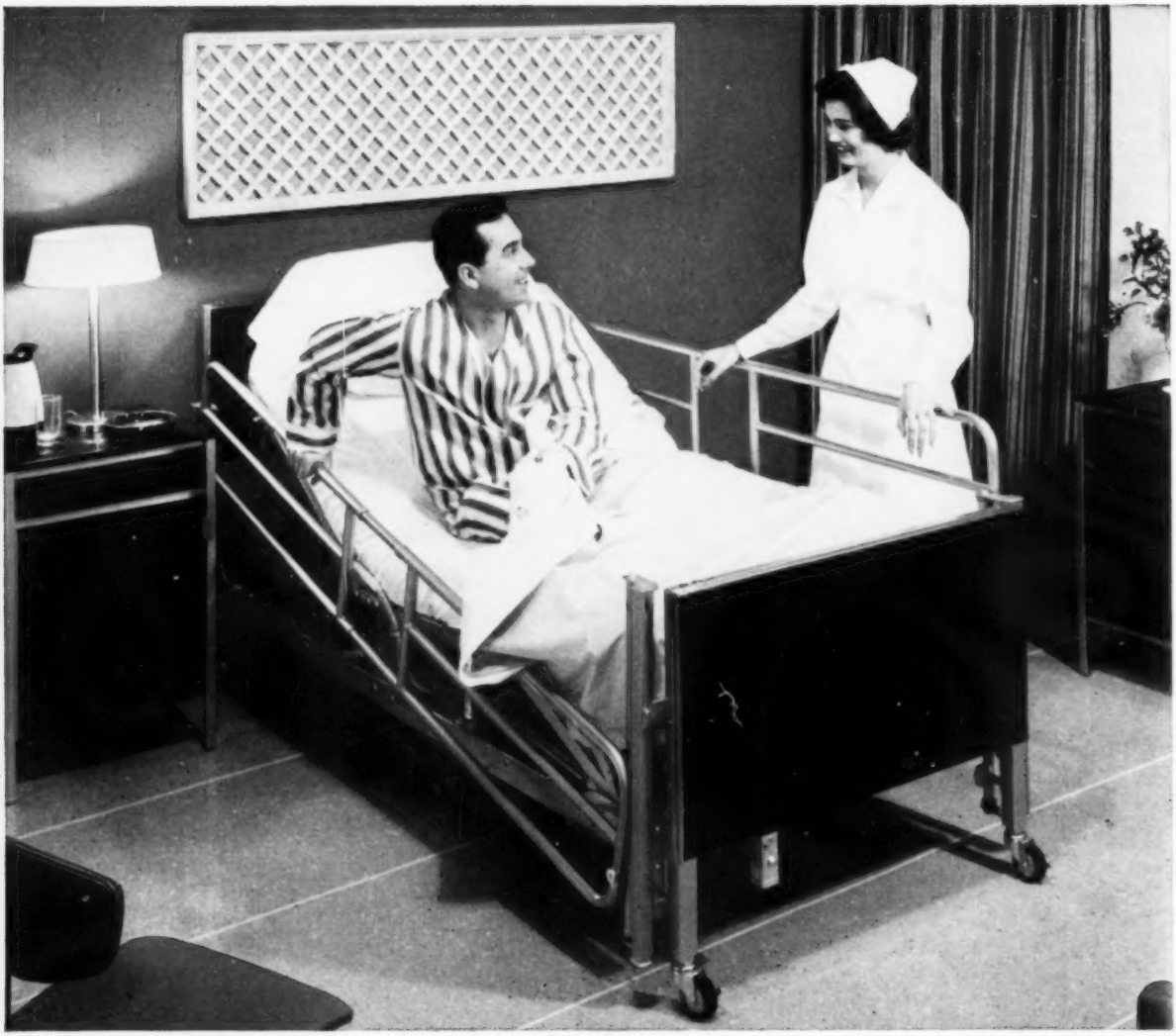
We can't go far in life if we row with one oar in the water and the other on the shore.



# SIMMONS H-333A-3 Motorized VARI-HITE Bed

## *from hospital to home height...at the flick of a switch*

Appreciated by both patients and nurses alike, Simmons Motorized VARI-HITE is the ultimate in hospital beds for ease and convenience.

It operates by means of a quiet, efficient ¼ H.P. motor which raises or lowers the bed at the touch of a switch. Fully enclosed and permanently lubricated, the A.C. motor runs on 110-120 volt line. Safety features include automatic protection against overload and overheat. The bed can be grounded at the wall socket if three-wire system not available.

Before leaving the factory, all Simmons VARI-HITE beds are tested under a 400 pound load for assurance of perfect working order.

Automatic limit switches turn motor off when bed has reached proper maximum or minimum position. Bed may be stopped at any desired intermediate height, or may be instantly reversed.

The spring is a proven model of Simmons improved Two-Crank Posture Spring. All posture positions, including shock and drainage, are possible.

Bed is equipped to take sliding safety sides, Irrigation Rod, Balkan Frame, Shaped Fracture Bar, Uni-Traction Fracture Bar and Bed Lamps.

**SIMMONS** LIMITED

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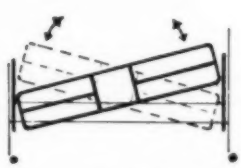

**For added patient safety and easier care** the H-875 Safety Sides can be either full-length or half-length to give the protection desired. The nurse can easily lower the head or foot end for quick access to the patient. Sides are finished in cadmium plate.

Illustrated are Simmons wonderfully practical H-965 Vivant Bedside Cabinet and Three-drawer Dresser, panelled in warm wood-grained Zalmite to match the bed.


Sometimes the solution to the day's grind
simply adds up to a welcome "pause that refreshes"
with ice-cold Coca-Cola.

Say "Coke" or "Coca-Cola"—both trade-marks mean the product of Coca-Cola Ltd.—the world's best-loved sparkling drink.

If something goes wrong, it is more important to talk about who is going to fix it, than who is to blame. —Francis J. Gable.



## Letter to the Editor

Dear Mr. Editor:

There is one magazine I always look forward to receiving and that is *Canadian Hospital*, and I read it religiously. There is always something in it that I find very helpful in my hospital duties. I think I have every copy on file since I first subscribed, as I find it a good reference part of my hospital library, which is now quite extensive.

I do not know how many comments you get on articles that appear in the magazine, but I do think it our duty, as readers, to express our opinions to you, not only by way of appreciation, but as a possible guide to you as to what your readers want.

I am therefore taking the liberty of writing, and commending you on the article by yourself in the last issue, entitled, "Healthy Hospital Associations". I think this article very timely and covers very thoroughly a subject which should be read by every hospital trustee and hospital association member.

There was a time when our provincial hospital associations could be of very little assistance and guidance to hospital trustees. This was because those very trustees took very little interest in association activities. Thank goodness the situation has changed, and trustees can no longer complain that help and guidance is not available to them through their own association; and they now realize that they should take full advantage of it. I think I touched briefly on this very thing in the short talk I gave at our recent convention.

I was very pleased to hear in the report from our executive director that we now have in Manitoba 100 per cent membership in our association, with all fees paid. This is something I once thought we would never achieve but had always hoped for.

This is the kind of thing that should urge all hospital workers, and particularly volunteer workers, to put forth greater effort in providing the best possible patient care in our hospitals. This has had that effect on me.

Again I cannot help but refer to the great honour that was recently conferred on me and the part played by you and Mr. Martin in making the presentation*. As the weather has now got cool I can enjoy warming my toes in front of my fireplace, and look back with pleasure to experiences of the past, particularly those in the hospital field.

Hoping that the *Canadian Hospital* may continue to serve its readers in the future, as in the past, and that you as its editor may continue to feel the pulse of those in need of hospital guidance in that field, I am,

**Yours sincerely,**
**(signed)**
**J. Milton George, Judge**
**Chairman, Morden Hospital Board**

**George Findlay Stephens Memorial Award.*

### To Entertain

Wrote Benjamin Franklin in 1753 in a note to Sister Elizabeth, matron of Pennsylvania Hospital: "Please to receive the Bearer into the Hospital, to entertain him there till the Physicians have considered his case."

## Hospital Consultants

### Activation Program

*(continued from page 37)*

(f) The use of equipment required while in the hospital;

(g) Such drugs, prescriptions, and similar preparations as may be designated by the B.C.H.I.S.;

(h) Diagnostic radiology and clinical laboratory services and such other services as may be considered necessary.

Benefits do not include treatment of tuberculosis, mental disease, alcoholism, the provision of out-patient service, "take home" drugs, prescriptions or certain appliances.

Some active treatment chronic and convalescent hospitals, and particularly paediatric institutions, already provide a fine range of out-patient and other special services supported mainly by public donations and government grants. While some, or part, of these programs do not qualify for coverage, every possible encouragement is given for their continuation. In fact, it has already been found that, contrary to popular opinion, there will be a greater need for voluntary support than ever before, since the extent of the needs of the long-term group is now beginning to come to light. Groups who have, in the past, supported the institutions providing coverage, should not withdraw their support —as some have suggested they might do—but should, instead, increase it, for there is now a greater need than ever before. The new program may not cover the full cost of the chronic care provided in some institutions, and voluntary support is needed to continue the good work of those groups which are conducting excellent programs in fields that lie outside the scope of the new plan.

Applications for coverage under the program must be supported by a medical report, based on a complete diagnostic examination. In most instances, this examination will be given in a general public hospital, since it is likely that the majority of patients will first be treated in general hospitals.

Necessary requirements for establishing medical eligibility have been developed; and, in this connection, the medical consultant of the B.C.H.I.S. has available specialized medical advice which has been arranged as a result of the conferences with the C.M.A., B.C. Division, and the faculty of medicine of the University of British Columbia.

Participation in the program is limited to approved active treatment chronic hospitals or chronic units that presented satisfactory evidence of ability and intention to provide a full chronic treatment service.

These hospitals are required to provide many or all of the following services, in addition to adequate nursing care:

(a) Physiotherapy and occupational therapy;

(b) Minimum laboratory diagnostic services (urinalysis, simple blood work, et cetera);

(c) A mobile x-ray unit capable of permitting accurate examination of an old fracture or a suspected new fracture;

(d) Minor surgical facilities sufficient to care for conditions not warranting transfer to a general hospital;

(e) Sterilizing and supply service capable of meeting all requirements for treatment trays, dressings, et cetera;

(f) Adequate medical records;

(g) Facilities for blood transfusions, intravenous therapy, and oxygen therapy.

The new program is under way and patients are being moved from some of the general hospitals to the designated chronic hospitals. Discussions concerning the type of patients to be covered are continuing, but gradually the pattern of care and patient movement is becoming clearer as more experience is gained with the new scheme. Administrative details regarding patients, their admission, method of payment to hospitals, and many other problems will continue to present themselves for some time in the future. However, one thing is certain, all parties concerned are working in close co-operation and are determined to develop a plan that will withstand close scrutiny from every point of view. Expanded out-patient services, home care programs and additional nursing or custodial facilities are programs that should be developed as rapidly as possible to support the new scheme.

Past experience in the acute program is proving worthwhile, and the orderly development of an activation program for the chronically ill seems assured for the future. ■

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The basic skill in every profession and in most businesses is the ability to organize and express ideas in writing and in speaking.



## Consulting Engineers

## University of Toronto School of Hygiene

**Fourth Annual Refresher Course**

The Fourth Annual Refresher Course in Public Health will be held in the School of Hygiene, University of Toronto, on February 6th, 7th and 8th, 1961.

This Course is designed to be of value not only for physicians who are interested in preventive medicine and administration, but also for hospital administrators and veterinarians. The first day will deal with various aspects of chronic diseases and the third day with animal diseases transmissable to man. The second day will be devoted to a consideration of protection from radiation hazards for the community. Full details may be obtained from the Director, School of Hygiene, University of Toronto.

Applications for the course should be made to the Director, Division of Postgraduate Medical Education, Faculty of Medicine, University of Toronto, Toronto 5, before January 14th, 1961. The fee is $35.00 for the whole course or $15.00 for one day only.

## Director of Nursing

Expanding 113 bed hospital, located in an attractive community one hour from downtown Toronto, requires a Director of Nursing to participate in the planning and organizing of an increase to 250 beds. Salary open.

Apply

**Administrator,**
**York County Hospital,**
**Newmarket, Ontario.**

**Director of Nursing**

for 80 bed general hospital, 20 miles from London. New hospital to be built early in 1961. Excellent personnel policies.

Apply to Administrator, Strathroy General Hospital or phone collect.

## A Chief Technologist Required

A Chief Technologist, preferably male, is required for the Pathological Laboratories of the Victoria Union Hospital, in Prince Albert. The Laboratory at present serves the requirements of 300 hospital beds, but it has become necessary to extend facilities to a number of hospitals in the rural areas. Applicants should be well trained in all branches of clinical Pathology and able to supervise the work of the laboratory generally, and assist in the training of student Technologists.

A generous salary wil be paid to the successful applicant.

**Apply to: The Administrator, Victoria Union Hospital, Prince Albert, Saskatchewan.**

## Business Manager

To assume business and some administrative functions in 113 bed general hospital close to Toronto. Expansion to 250 beds planned for the near future.

**Apply:**

**Administrator,**
**York County Hospital,**
**Newmarket, Ontario.**

**General Duty Staff Required**

for 80 bed hospital, 20 miles from London. Accommodation available in residence, excellent personnel policies.

Apply to Administrator, Strathroy General Hospital.

## Registered Medical Records Librarian Required

To take complete charge of the Medical Records Department in this modern 300-Bed General Hospital. Personnel Policies include 5-day week, 3 weeks paid annual vacation and other generous employee benefits.

Sarnia is located midway on the Seaway, and 60 miles north of Detroit and Windsor.

There are excellent opportunities for adult education and recreation in this area.

Apply giving complete details regarding qualifications, experience and salary expected to:

Personnel Director,
**Sarnia General Hospital,**
Sarnia, Ontario.

## Registered Dietitian Required Male or Female

Required immediately for therapeutic diets and dietetic training of student Nurses. Good employee benefits including 40 hour work week, sick leave, four weeks' annual vacation, pension and medical care plan. Apply stating qualifications, salary expected and when available to

**Personnel Manager,**
**Moose Jaw Union Hospital,**
Moose Jaw, Saskatchewan.

## DIETITIANS REQUIRED

Qualified Dietitians for 450-bed accredited hospital. Large Student School. New and modern Dietary Department, cafeteria and trayveyor service. Salary commensurate in accordance with C.D.A. recommendation. Day shifts only. Liberal holidays, sick leave, pension plan and other perquisites. Excellent working conditions and quarters prevail. Transportation refundable after six months.

Apply Director of Dietetics,
**McKellar General Hospital,**
Fort William, Ontario

## Kingston General Hospital

**invites applications for position of**

## DIRECTOR OF NURSING

The hospital is situated in the cultural and historic city of Kingston. The new Connell Wing recently opened increased bed capacity to 625. A modern new cafeteria, with a nurses' training school completes a brief picture of this fully accredited general hospital. Salary is dependent on qualifications and experience. Excellent personnel policies with 4 weeks annual vacation, pension and medical plans. For further information, address enquiries to:

*Superintendent*

**KINGSTON GENERAL HOSPITAL**
**Kingston** **Ontario**

## Administrator Wanted

Applications will be received for the position of Administrator for Kenora General Hospital. New construction will start in the near future on expansion and renovation of the present structure, to provide for 125 beds. The Administrator will be expected to work with the Architects during construction period, and to develop a complete administrative organization for operation of the hospital. He must have a broad experience in both hospital construction and administration. Please state qualifications, experience and salary expected. Address all applications to

**Secretary, Board of Directors,**
**Kenora General Hospital,**
**Kenora, Ontario.**

## Physician Required

Hospital Accreditation program requires physician, preferably bilingual to act as surveyor and assistant to the Executive Director. Duties to start February 1, 1961. Appointee needs good knowledge of hospital and medical staff organization and administration to evaluate and make sound professional judgment on hospital and professional activities and to educate and recommend on accreditation standards and methods of procedure. Appointee to spend major portion of the year doing and reporting hospital surveys. One month's holidays. Salary according to qualifications and experience. Apply in writing giving curriculum vitae, experience, references as applicable and salary expected, to

**Dr. W. I. Taylor,**
Canadian Council on Hospital Accreditation, 150 St. George St.,
Toronto 5, Ontario.

## Hospital Administrator

Required to assume position of Administrator, January, 1961 for new modern sixty-six bed hospital, opening June, 1961.

All applications will be acknowledged and treated in confidence. State qualifications, experience and approximate salary expected.

Apply to: Chairman, Hospital Committee, Georgetown and District Memorial Hospital, Georgetown, Ontario.

## Assistant Medical Records Librarian Wanted

The University Hospital at Saskatoon, Saskatchewan has an opening for an Assistant Medical Records Librarian. Would consider a student of the Extension Course for Medical Records Personnel. Salary commensurate with experience or degree of training. **Apply to the Personnel Office.**

## Dietitians Required
## Brantford General Hospital, Brantford, Ontario.

Applications are invited from C.D.A. Qualified Dietitians for Senior and Junior positions in the modern Dietary Department of the Brantford General Hospital. We offer a 40 hour week, 8 statutory holidays, 4 weeks yearly vacation with pay, liberal sick benefits and pension plan.

Salary will be set in accordance with qualifications and experience.

Please address enquiries to:

**Director of Dietetics,**
**Brantford General Hospital,**
**Brantford, Ontario.**

## Associate Pathologist Required

The Royal Alexandra Hospital requires an Associate Pathologist. The salary is open depending on experience and qualifications. The hospital has 729 beds and is expanding to 1300 beds. Applications should be directed to **Dr. D. R. Easton, Executive Director.**

## Assistant Superintendent
(Finance)

for 600-bed General Hospital. A mature person, with administrative ability, is required to fill a Senior position. C.A. qualification desirable. Give detailed resume of education and experience and include references. State marital status, age and when available.
All applications will be kept confidential.

Reply to **Box No. 1203 K, Canadian Hospital, 25 Imperial Street, Toronto 7, Ontario.**

## For Sale

We have 2 National Cash Posting Machines (Series 2000) for sale; one is 18 years old and one is 8 years old. These machines are presently set up for posting accounts receivable. Anyone interested please contact Mr. S. G. Anderson, Assistant Administrator, (Finance) Ottawa Civic Hospital.

## Hospital Administrator

seeks challenging position in 100-250 bed hospital. Competent all phases of smaller hospital administration, very extensive high level administrative qualifications and experience outside hospital field. Having just completed extension programme would welcome position with hospital planning expansion. Willing to accept subordinate position in larger hospital.

**Replies please to Box 1201 D, Canadian Hospital, 25 Imperial Street, Toronto 7, Ontario.**

## Hamilton General Hospitals

Invites applications from QUALIFIED MEDICAL SOCIAL WORKER for the Nora-Frances Henderson Hospital Unit. The salary according to experience. Excellent fringe benefits. Applications to be forwarded as soon as possible to: Personnel Office, Hamilton General Hospitals, Barton Street East, Hamilton, Ontario.

## Administrator Available

1958 Graduate of the Extension Course in H.O.M. Age 45, 6 years experience as: accountant and business manager, 385 beds; administrator, 99 beds; business manager and assistant administrator, 200 beds (present). Specially able in all areas dealing with financial management. Willing to consider post as assistant in a progressive hospital. For further details apply to Box 1224 G, Canadian Hospital, 25 Imperial Street, Toronto 7, Ontario.

## Position Wanted

Accountant, 52, married, registered, trained in Hospital Administrative and Audit Procedures. Available January 1/61. Please write to **Box 1202 M, Canadian Hospital, 25 Imperial Street, Toronto 7, Ontario.**

# . . . Across the Desk

*News Released by Hospital Supply Houses*

### Union Carbide's Architectural Showpiece

Union Carbide Canada Limited's architectural showpiece on Eglinton Avenue East in Toronto has been hailed as "Canada's most elegant office building" by Alan Jarvis, former director of the National Gallery and a leading architectural critic. The 11-storey building, which was recently occupied by the Company and its six divisions, boasts several "firsts" in design and interior decoration.

Included in these is the largest application (75 tons) of stainless steel in Canada; the longest clean span (61 feet) of any office building on the North American continent; the complete absence of interior columns, and the first use of "Dynel" fibre carpeting in this country. Additionally, the moveable steel partitions for the interior offices were especially fabricated for the building. The exclusive use of ivory-coloured telephones throughout (350 of them) is an innovation in Canadian office practice.

Described by the architects, Shore and Moffat, Toronto, as "machine-made Gothic", the Union Carbide building has aroused interest among businessmen and contractors because of its combination of spacious beauty and utility. Conveying the image of a dynamic, progressive company, the building has been stripped of unnecessary superficialities while maintaining a highly functional interior design that provides a stimulating environment for the employees.

Cost of the building was approximately five million dollars plus one million dollars for the property.

### Cyanamid Improves Suture Handling Techniques

A free service program for resterilizing and repackaging SP plastic surgical suture envelopes has been announced by the Medical Products Department of Cyanamid of Canada Limited. The announcement was made recently by Ralph B. Thompson, manager of the department.

The unique program is intended to save up to two days per week in time spent by operating room nurses on suture resterilization and will result in increased safety for patients and operating room personnel by improving suture handling techniques. It is the first completely dry suture technique devised for hospitals.

The program is being offered to hospitals using Cyanamid's Surgilope SP Sterile Suture Strip Pack, a double plastic envelope with the suture contained in the inner envelope. The outer seal is stripped back at the start of the surgical procedure and the inner envelope opened just prior to use.

Previously, unopened inner envelopes had to be resterilized by the hospital itself following surgery. Under the new plan, the operating room supervisor will merely collect the envelopes and ship them to Cyanamid's Medical Products Department in Montreal, where they will be resterilized and repackaged in an outer envelope.

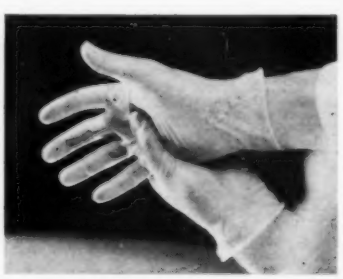
The hospital's original sutures will be returned approximately eight weeks from the date they are shipped to Montreal. Three weeks of bacteriological tests guarantee that they are certified sterile U.S.P.

For complete instructions regarding shipping, write to Cyanamid of Canada Limited, 635 Dorchester Blvd. West, Montreal.

### Superior Sensitivity, Good Fit With New B-D Disposable Glove

Becton, Dickinson and Company, Rutherford, New Jersey, has announced a major product development in the plastic disposable examination glove field. The glove, called Wilson Tru-Touch, is made from a polyvinyl formulation and offers extraordinary sensitivity, has no seams, and is strong enough for any type of digital examination.

The Tru-Touch glove materially aids the medical practitioner in his work as it offers tactile perception which, it is said, is superior to that available with latex gloves, and eliminates the time required by nurses or aides in cleaning and resterilizing latex gloves.



According to William S. Little, B-D vice president for sales, "The glove as presently marketed primarily is designed for examination use. Surgical gloves require slightly greater durability and strength than afforded by the present glove design.

"However, with minor changes, we can make a surgical glove with

*(continued on page 86)*

# NEW A.C.M.I. STERILE PACKAGED

## INFLATABLE CATHETERS


- Save nurses' time
- Eliminate autoclaving expense
- Reduce patient-care costs

### *Double protection*

***...double safety...***

***ready for instant use***

The new A.C.M.I. Sterile Packaged Premium Catheter is double-protected by double packaging, for *assured* sterility. Even should the durable outer non-peelable package be torn or cut by unduly rough handling, the resilient inner peelable package still protects the sterile catheter from contamination.

Sterilization is achieved under rigidly controlled conditions; and is checked by thorough bacteriological testing before each lot is released. These catheters meet U.S.P. sterility standards and government specifications.

FREDERICK J. WALLACE, *President*

*American Cystoscope Makers, Inc.*

PELHAM MANOR, NEW YORK

*Distributed in Canada exclusively by*

INGRAM & BELL LIMITED

TORONTO

MONTREAL · WINNIPEG · CALGARY · VANCOUVER

### Across the Desk
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substantially the same advantages and physical properties as the present examination glove. Such disposable surgeons' gloves will be available within the next few months."

For further information about this new glove, write to: Mr. J. H. McLellen, Becton, Dickinson and Company, Rutherford, New Jersey.

### New Waste Receptacle Has Built-in Sanitizer

A new, professional model waste receptacle has several innovations. The Air*San is a smooth, foot operated receptacle with "Magic-Close" that permits silent closing.

An individual Ozium-Glycolized air spray-dispenser is built into each unit. Pressing the button on top of the receptacle releases a measured spray onto the contents. Each cartridge in the sanitizer delivers between 250 and 300 sprays.

The rust-proof, Epon-coated removable liner is stain-proof and impervious to most chemicals and alkalis. The unit is finished in white, with a chrome top. The receptacle measures 11½" x 11" x 19".

Further information may be obtained from G. H. Wood & Company Limited, Box 34, Toronto 18.

### Data Processing and Accounting by Telautograph Telescriber

In data processing or accounting applications, the new Telautograph machines provide an extremely flexible method of creating source data. In such situations as order entry, material release, receiving or inventory control, telescribers have the capacity to transmit operating reports at the same time source documents are being created. Information is dissembled immediately. At the same time, the system has a built-in audit trail.

For hospitals these telescribers are expected to offer improved registration and service controls. One standard application calls for the installation of a telescriber at the main switchboard for the handling of messages. Another involves the use of telescribers for services and charges. Telescribers are located at nursing of housekeeping stations. They link other service departments, such as kitchens, x-ray, pharmacy, et cetera.

From all service areas, charge information is funnelled to the accounting department for immediate charge entries. Both work scheduling and accounting operations are approved. In cases where an institution operates with more than one building, registration information, including the signing in of doctors, can be forwarded by telescriber so that the main office always knows the occupancy status.

For literature, please write to Automatic Electric Sales (Canada) Limited, 185 Bartley Drive, Toronto 16.

### Catalogue of New Laboratory Gas Mixtures

Ohio Chemical & Surgical Equipment Co. (A Division of Air Reduction Company, Inc.), has announced the availability of their new Laboratory Gas Mixtures Catalogue. Nine separate gases are offered in two and three compatible mixtures. The catalogue includes tables on the gas properties, cylinder contents and prices of both cylinders and gas mixtures. Also included is regulating equipment.

To obtain a copy, please write directly to Ohio Chemical Canada Limited, 180 Duke St., Toronto.

### Air-Shields Humidifier Provides Cool Vapour

Cool vapour, so refreshing and therapeutically important to victims of croup, asthma, bronchitis, pneumonia and other respiratory ailments, as well as to post-operative patients, can now be provided without encumbering tents, canopies or masks. The new compact "Croupaire" cool vapour humidifer, developed by Air-Shields, Inc. is designed to deliver a refreshing, healing "fog stream" of moisture-laden air directly to the patient.

Occupying table space of 14 x 7½ inches, and weighing just 6 lbs., the quiet Croupaire may be conveniently placed at the bedside, easily moved from room to room and plugged into any AC outlet. Its therapeutic fog stream of cool vapour contains minute water particles in the sizes that most easily permeate and moisten the entire upper respiratory tract. At a distance of 2½ to 3 feet, the droplets range from 2.6 to 18.2 microns in diameter.

Water is drawn up from the ample reservoir through the hollow axle of a disc spinning at 9,000 r.p.m. Centrifugal force flings the water from the disc to smash against the serrated edges of an ingenious circular baffle. Thus, a fine vapour containing micronized water particles is produced within the unit.

A paper entitled, "Moisture, The Will of The Wisp," explaining the important part humidity plays in breathing, is available from Air-Shields (Canada) Ltd., 8 Ripley Avenue, Toronto 3, without obligation.

### Rectalyt is new Doho Rectal Medication

Available in a soft plastic, disposable, measured, uniform single dose container-applicator, a really new water-miscible polymer vehicle containing Hydrocortisone and the new Sulfonamide, Sulfauridin, has been developed in the Mallon Research Laboratories of DOHO.

Because of the inherent qualities of Rectalyt's polymer base, the

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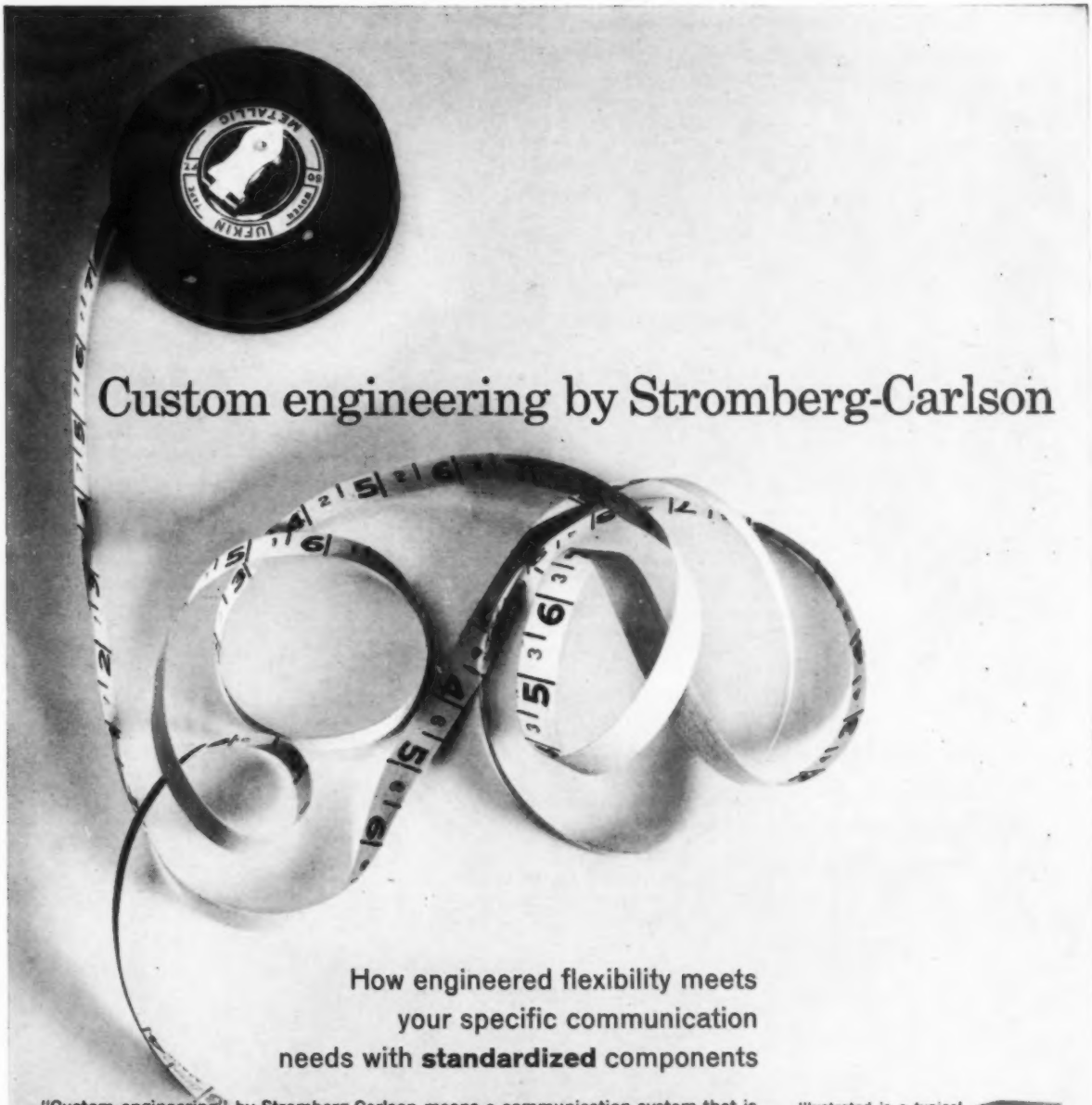


# Custom engineering by Stromberg-Carlson

## How engineered flexibility meets your specific communication needs with **standardized** components

"Custom engineering" by Stromberg-Carlson means a communication system that is ideally suited to your specific application—**without** the maintenance and service problems that can accompany custom-made equipment.

Each Stromberg-Carlson system is composed of **standardized** components—the basic building blocks—and is fashioned by customized application engineering to meet the requirements of your plant. This arrangement assures the greatest possible flexibility at the lowest possible cost.

What's more, you get the reliability, minimum maintenance and minimum service requirement inherent in using proven, standard components. And you have a built-in guarantee against obsolescence, because your system can be expanded or adapted to meet changing conditions—still with **standard Stromberg-Carlson components.**

The Stromberg-Carlson distributor, an expert Communications Consultant, will be happy to discuss with you the specific needs of your plant and help you decide how a communication system by Stromberg-Carlson can best meet them. Find him in the Yellow Pages under "Public Address & Sound Equipment," or write to Special Products DIVISION, HACKBUSCH ELECTRONICS LTD., 23 PRIMROSE AVE., TORONTO 4, ONTARIO

Illustrated is a typical SS-800 "custom-engineered" paging or background music system, one of many possible customized arrangements of standard Stromberg-Carlson components.

A Dial-X® private telephone intercom system can either be "tied in" to the paging system or used independently.

Perhaps the needs of your plant can best be met by a Pagemaster® selective radio-paging system.

"Key - municator" loudspeaking intercom system is still another aid to more efficient operation.

*Exclusive Canadian Representatives*

**HACKBUSCH ELECTRONICS LIMITED**

**STROMBERG-CARLSON**

A DIVISION OF GENERAL DYNAMICS CORPORATION

### Across the Desk
*(continued from page 86)*

active ingredients cling to the wall of the rectal canal and spread upwards into all folds, cracks and crevices in an ever-widening area along the lining of the rectal pouch.

Unlike suppositories, Rectalyt does not soil hands or clothes. Unique container - applicator is used once and discarded. It is always ready for use, and needs no refrigeration.

A new DOHO film, entitled "Destruction of Living Human Cells By Virus," is available gratis to medical societies, hospitals, universities and professional study groups exceeding twenty persons.

Particulars regarding a loan of this excellent film may be obtained by writing to DOHO Chemical Co. Ltd., Montreal 3.

### Cordley Coolers for 1961 Include Five New Models

Five new floor-type water coolers, which, it is said, save as much as 25 per cent in space, will be offered for 1961 by Cordley & Hayes.

The new Cordwalls feature concealed plumbing, flush-wall installation or free-standing, and air-cooled or water-cooled models.

The new units, which can be tied to plumbing in the wall or through the floor, provide connections for remote fountains and glass fillers.

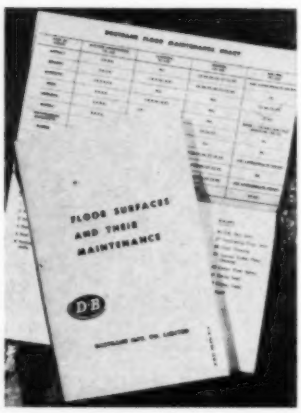
The original Cordwall was introduced early in 1960 as a wall unit mounted off the floor, with concealed plumbing. Three models for mounting on the wall are currently available, in addition to the new floor models. At its debut, the Cordwall was lauded as an "exciting departure" in electric cooler design by architects and engineers.

As with all Cordley Coolers, the sealed refrigerant and water systems of the new Cordwalls are protected by Cordley & Hayes' unique five-year guaranty. The units comply with all sanitary codes and requirements of Commercial Standards CS127-45 of the National Bureau of Standards.

For more information, write Cordley & Hayes, 443 Park Avenue South, New York 17, New York.

### Dustbane Booklet on Floors and Maintenance

"Floor Surfaces and Their Maintenance," an outline of the most common floor types and their characteristics and materials recommended for their maintenance, is the latest technical bulletin




release offered by Dustbane Mfg. Co. Limited. This 16-page, pocket size booklet (D12) is available on request. Write to 88 Metcalfe Street, Ottawa, Ontario.

### New I-D Bracelet Introduces Unique Features

Made of non-toxic, high tensile, opaque white polyvinyl chloride with simulated leather grain, the Mark-Clark I-D bracelet comes complete, ready for attachment in seconds to wrist or ankle. The standard size bracelet is adjustable from 4¼" to 9½" circumference through a series of 15 precision punched adjustment holes. Infant sizes are adjustable from 3" to 5" through 7 adjustment holes. Simple finger pressure closes the Perma-Lock snap closure, a new irreversible snap fastener which assures positive, permanent attachment.

Other outstanding features include the I-D Card holder which is electronically fused directly into the band, making it water-resistant and tamper proof. White I-D Card, measuring 2½" x 11/16", allows space for all information recommended by hospital authorities. The card is easily inserted, permanently locked in position, and fully visible at all times. Special size, pink and blue cards are available for infants.

Complete information, literature, and prices can be obtained by writing Mark-Clark, Inc., 301 North Water Street, Milwaukee 2, Wis., or Ingram & Bell Limited, exclusive Canadian distributors, 256 McCaul St., Toronto 2B.

### Dramatic New X-Ray System Comes to Canada

One of the most dramatic advances in the 60-year history of x-ray technology was introduced in Toronto recently by RCA Victor Company, Limited.

The development is the revolutionary 9 inch Image Intensifier diagnostic x-ray system, made by Keleket X-ray Corporation of Waltham, Mass., and distributed in Canada by RCA Victor. The Image Intensifier, displayed in a mobile trailer unit, was on view to the medical profession and x-ray technicians at the Seaway Hotel.

The Image Intensifier is a device that replaces a standard fluoroscopic screen and electronically intensifies the image over 3,000 times. The important benefit to the patient is that this allows a great reduction in radiation exposure. By means of the much brighter image, giving over ten times more detail than conventional fluoroscopes, and an electronic grid control cine

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**Across the Desk**
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system, radiation is cut by over 50 per cent.

The mobile trailer display combined the latest cine and television attachments. The cine system is being recognized as the most thorough means of analysis.

Full particulars available from RCA Victor Co. Limited, 976 Lacasse St., Montreal 30.

### Baxter Chairman, Dr. R. Falk, Dies in Chicago

Dr. Ralph Falk, Chairman of the Board of Baxter Laboratories, Inc., Morton Grove, Illinois, and a pioneer in the development of intravenous feeding, died in Wesley Memorial Hospital, Chicago, Illinois, November 2 after a brief illness.

Dr. Falk, 76, who practised surgery until recent years, was president of Baxter from its inception until 1953, when he assumed the chairmanship. Baxter was organized in 1931 and began production of intravenous solutions with six employees in Glenview, Illinois, in 1933. Dr. Falk guided the firm to its present position as a diversified company with more than 2,000 employees and with manufacturing facilities throughout the world producing pharmaceuticals and equipment for the medical profession.

*Dr. Ralph Falk*

The Canadian plant is located at Alliston, Ontario.

### New Tsi Tape Shows "Sterile" After Sterilizing

The Professional Tape Company has recently developed a very accurate chemical combination of ingredients to respond to the standard autoclaving or sterilizing cycle of 250°F for a period of 15 minutes. This chemical is applied to a pressure sensitive paper tape constructed in portable form so that it can be cut and removed and placed on any type of package.

This labelling tape known as "Tsi Tape" (Time Sterile Indicator Tape) fills a wide vacuum existing in the scientific field of hospital procedures, it is claimed. When properly used on any package, any wrap or any container, the black word "Sterile" appears after sterilizing only at the required sterilizing cycle values. Thus the use of this "Tsi Tape" articulates the function of the operator responsible for this critical action necessary for all hospital materials. It not only provides a check on the efficiency of the operator, but it identifies the condition of the product for the user.

In keeping with the advancement of science, "Tsi Tape" provides a new technique establishing a standard which will bring greater safety and efficiency in operation to every hospital. No modern operation should be without this dramatic influence controlling the action in usage of hospital materials.

For more details, write to Professional Tape Co., Inc., 355 Burlington Road, Riverside, Illinois.

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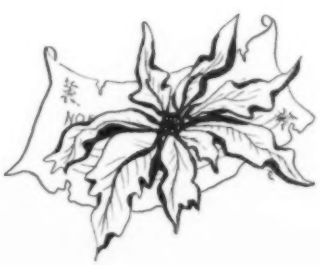

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